

**SAN FRANCISCO
HEALTH SERVICE SYSTEM**

Affordable, Quality Benefits & Well-Being

**GOVERNANCE POLICIES
AND
TERMS OF REFERENCE**

Revised February 2019

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Affordable, Quality Benefits & Well-Being

Health Service Board Governance Manual Revised February 2019

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101: HEALTH SERVICE BOARD TERMS OF REFERENCE

Introduction

- 1) SFHSS has established the following mission statement:

SFHSS is dedicated to providing outstanding health and other employee benefits to its members while adhering to the highest standards of customer service.

- 2) To carry out its mission and the responsibilities of the SFHSS set out in the City Charter (“Charter”) and Administrative Code, the Board believes it must establish clear roles and responsibilities for itself and all other parties involved in the governance and management of the SFHSS. The Board has established these terms of reference to confirm and build upon the Board’s statutory duties.
- 3) In the event of a conflict between the City Charter or the Administrative Code and the terms of reference or governance policies adopted by the Board, the City Charter and Administrative Code will prevail.

Duties and Responsibilities

General Duties

- 4) Consistent with Charter section 12.201, the Board and each committee of the Board shall confine its activities to policy matters and to matters coming before it as an appeals Board.
- 5) The Board’s duties fall into two broad categories:
 - a) Designing benefit plans and benefit changes and determining rates in connection with the provisions of Charter section A8.422, subject to final approval by the Board of Supervisors; and
 - b) Health and welfare plan and fund administration in connection with:
 - i) The Health SFHSS Trust Fund, pursuant to section 12.203;
 - ii) Benefit plans adopted pursuant to A8.422; and
 - iii) Benefit plans administered by the Board pursuant to section 4.102.

Plan Adoption and Benefit Design

- 6) In accordance with Charter section A8.422, the Board has an important role to play in designing health benefit plans and amendments thereto for adoption by the Board of Supervisors:

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- a) The Board shall have power and it shall be its duty by a majority vote of the entire membership of the Board to adopt a plan or plans for rendering medical care to members of the SFHSS, or for obtaining and carrying insurance against such costs or for such care. Such plan or plans as may be adopted, shall not become effective until approved by ordinance of the Board of Supervisors, adopted by three-fourths of its members; [A8.422] and
 - b) Consistent with the plan year set by the Board, at a public meeting, the Board shall review and determine the adequacy of health care provided for members of the SFHSS and the adequacy of fee schedules and the compensation paid for all services rendered and it may make such plan revisions as it deems equitable, however, such revisions shall not become effective until approved by ordinance of the Board of Supervisors adopted by three-fourths of its members.
- 7) To facilitate carrying out the duties set out in paragraph 6 above, the Board shall approve:
- a) The annual benefit and rate setting process; and
 - b) The Rates and Benefits Review cycle will guide the goals/objectives for the Board so that they can carry out the health care adequacy review. This process was referred to in section 6) b).

Board Governance

- 8) The Board is responsible for ensuring effective governance practices in respect of the Board.
- 9) The Board shall approve, and amend, as necessary:
 - a) An Annual Statement of Purpose (Charter § 4.102);
 - b) Rules and regulations consistent with the Charter and Ordinances at least annually and as necessary consistent with Charter section 4.104(1);
 - c) Terms of reference describing the roles and responsibilities of the Board, Board committees, Board officers, the Executive Director, and if applicable the Medical Executive Director;
 - d) Any governance-related policies necessary to help ensure appropriate governance practices at SFHSS; and
 - e) A Board Education Plan.
- 10) The Board shall:
 - a) Elect a President and Vice-President of the Board on an annual basis;
 - b) Establish standing or ad hoc committees or task forces as necessary;

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- c) Appoint Board members and a chair to each standing committee, ad hoc committee and task force, upon the recommendation of the President;
- d) Ensure that a Board orientation and continuing education program is in place to assist Board members in securing the knowledge they require to properly execute their duties;
- e) Annually conduct a Board performance evaluation, in which the members of the Board may evaluate the performance and practices of the Board during the prior year and suggest opportunities for improvement;
- f) When budget permits, approve travel requests by Board members for education or other business purposes pertaining to SFHSS; and
- g) Ensure that a record of the proceedings of Board and Committee meetings is maintained.¹

Benefit Administration

- 11) The Board shall ensure the administration of health and wellness plans adopted by the Board of Supervisors under Charter section A8.422, and health and welfare plans established by the Mayor and the Board of Supervisors under Charter section 4.102.
- 12) The Board shall ensure that management implements benefit and administration policies intended to ensure efficient and effective administration of all benefit plans it administers, addressing for example such things as membership rules, the annual rates and benefits setting process, service quality standards, member communications, open enrolment rules, confidentiality of member data, and performance evaluation of vendors.
- 13) The Board shall establish and, at least annually, review and if necessary amend the SFHSS Rules in compliance with section 125 of the internal revenue code.

Investment Administration

- 14) The Board shall administer the Health SFHSS Trust Fund in accordance with the Charter solely for the benefit of the active and retired members of the SFHSS and their covered dependents. [Charter § 12.203]
- 15) The Board shall have control of the administration and investment of the Health SFHSS Trust Fund, provided that all investments shall be of the character legal for insurance companies in California. [A8.429]
- 16) In keeping with its fiduciary duty to prudently administer the Health Service Trust Fund, the Board shall be responsible for:
 - a) Approving a written investment policy statement, and reviewing, confirming, or amending such policy at least annually.

¹ As required under the *San Francisco Sunshine Ordinance*, Administrative Code, Chapter 67.

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- b) Ensuring qualified parties are appointed to manage the assets of the Health SFHSS Trust Fund.
- c) Ensuring regular compliance monitoring in regard to the investment policy statement.
- d) Ensuring ongoing review of the investment performance of the Health Service Trust Fund.

Rates and Accounting

- 17) The Board shall adopt funding policies to ensure the financial health and integrity of each self-funded plan and shall be reviewed annually and, when necessary, amend said policies. The funding policy shall also address any other reserves to be held in the Health SFHSS Trust Fund. The policy may address, among other things, appropriate reserve targets for unanticipated needs and claims that are incurred but not reported (IBNR), the actuarial methodologies and assumptions to be used in determining reserves, and subsidies.
- 18) At such time consistent with the plan year set by the Board, the Board shall ensure a survey is conducted of the 10 largest counties in California, other than the City and County of San Francisco, to determine the average contribution made by each employer of such county to health benefit coverage. In accordance with the survey, the Board shall determine the average contribution made with respect to each employee by the 10 counties toward the health care plans provided for their employees and shall certify to the Board of Supervisors the amount of such average contribution. [Charter § A8.423]
- 19) The Board shall:
 - a) Ensure that management implements mechanisms to collect all required contributions to the Health SFHSS Trust Fund and to make all distributions in a timely manner;
 - b) Ensure historical records on costs are maintained;
 - c) Ensure appropriate financial and operational controls are established by management;
 - d) Ensure funding is in place to provide for the external financial audit;
 - e) Review with management significant accounting policy changes, as required; and
 - f) Review and accept the annual audited financial statements and external auditors' management letter and take corrective action if required.

Organizational Planning & Risk Management

- 20) The Board shall annually approve:

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- a) A strategic plan, which may include a mission statement for the SFHSS, the broad direction and goals of the SFHSS, and the specific projects that must be completed to fulfill SFHSS' broad direction and goals;
- b) An annual administrative department operating budget;
- c) The basic organizational structure of the SFHSS; and
- d) Outsourcing strategies with respect to cores services of the SFHSS, i.e., whether certain activities will be performed by an outside agent rather than SFHSS staff.

21) The Board shall ensure management develops, over time, an ongoing system of operational risk management and that management reports to the Board at least annually on such system. This may be accomplished as part of the strategic planning process, if deemed appropriate by management and the Board.

Human Resources

22) The Board shall:

- a) Appoint an Executive Director and determine the duties and responsibilities of the position;
- b) Establish a process for evaluating the performance of the Executive Director, and annually evaluate the Executive Director accordingly;
- c) Establish and annually review the compensation of the Executive Director within the ranges of the classification set for the position; and
- d) Ensure the Executive Director documents the delineation of managerial authority and responsibility within the SFHSS in the event the Executive Director is absent or unavailable to perform the Executive Director's duties for an extended period of time, along with any related procedures to ensure continuity in SFHSS operations. The Executive Director shall review such documentation, and any updates thereto with the Board, from time-to-time, subject to open meeting law requirements.

Communications

23) The Board shall:

- a) Ensure that an annual report is prepared describing its activities, and shall file such report with the Mayor and the Clerk of the Board of Supervisors; [Charter § 4.103]
- b) Hold meetings open to the public and encourage the participation of interested persons; [Charter § 4.104.2]

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- c) Conduct its meetings in accordance with the *San Francisco Sunshine Ordinance* (San Francisco Administrative Code, Chapter 67), and the *Ralph M. Brown Act* (California Government Code Section 54950 et seq.);
- d) Ensure that information is obtained and disseminated to the members of the SFHSS with regard to plan benefits and costs thereof; [Charter § A8.423] and
- e) Work with the Executive Director to ensure other mechanisms and procedures are in place to enable accurate, co-ordinated, and effective communications between the SFHSS and its stakeholders, including plan members, the City, other participating SFHSS employers, and employee groups.

Legislation and Litigation

- 24) The Board may, in closed session, consider and approve recommendations made by the Executive Director or legal counsel concerning settlements or other legal actions involving SFHSS.

Selection of Vendors

- 25) The Board shall establish appropriate policies to help ensure effective and prudent selection of service providers.
- 26) The Board recognizes that it is neither effective nor efficient for the Board to be involved in the selection of all service providers. Accordingly, the Board shall be responsible for approving the awarding of final contracts for the following primary service providers named below:
 - a) Actuaries;
 - b) Insurance carriers;
 - c) Hearing officers or firms providing the services of hearing officers;
 - d) Third party administrators retained for services in connection with non-charter benefits and with a contract value in excess of \$200,000 annually;
 - e) External information technology consultants retained for services with a value in excess of \$200,000;
 - f) Services of a Medical Executive Director; and
 - g) Investment managers or advisors
 - h) Other service providers, as may be determined by the Board.
- 27) It is recognized and understood that the following services are provided or co-ordinated by various departments within the City:

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- a) Financial and operational audit services;
 - b) Custody services;
 - c) Legal services;
 - d) Investment management and advisory services; and
 - e) Information technology services.
- 28) The Board shall communicate to the Executive Director regarding secondary service providers or classes of services providers, which the Executive Director shall be authorized to select, and the Board shall determine the controls to be put in place with respect to such authority; such as, for example, dollar limits on expenditure authority.

Monitoring

- 29) The Board shall ensure that appropriate monitoring and reporting practices are established and documented within SFHSS.
- 30) The Board shall periodically review compliance with, and the continued appropriateness of, any policies adopted by the Board including, but not limited to, policies in the following areas:
- a) Governance policies and terms of reference;
 - b) Benefit design policy;
 - c) Funding policies:
 - i) Stabilization reserve policy.
 - ii) Incurred but not reported policy.
 - iii) Contingency reserves policy.
 - d) Investment policy;
 - e) Health Service System rules;
 - f) Communication policy; and
 - g) Accounting policy.
- 31) The Board shall monitor periodically:
- a) The levels of the reserves (on not less than a quarterly basis);
 - b) The adequacy of rates, including a retrospective review of rate-setting; and
 - c) The investment performance and costs of the Health System Trust Fund.

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- 32) The Board shall ensure periodic reviews of the performance of key service providers including but not limited to insurance carriers and third-party administrators relative to pre-established performance criteria.
- 33) The Board shall ensure the periodic monitoring of usage and participation levels by members within the health plans, and the general affordability of the plans it administers.
- 34) The Board shall monitor the levels of service quality provided by the health plans and other benefit plans sponsored by the SFHSS, developing over time the methodologies necessary to do so.
- 35) The Board shall monitor:
 - a) Implementation of the Strategic Plan; and
 - b) Compliance with the SFHSS Operating Budget.
- 36) At least annually, the Board shall review the performance of:
 - a) The Executive Director; and
 - b) The Board itself.

History

- 37) These terms of reference were adopted by the Board on February 22, 2007; amended on April 9, 2015. Further amended on February 14, 2019.

Review

The Board shall review these terms of reference at least every three years.

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102: PRESIDENT OF THE HEALTH SERVICE BOARD TERMS OF REFERENCE

Introduction

- 1) Unless otherwise agreed by the Board, at its regular meeting in June of each year, the Board shall elect one Board member to serve as President. The President shall take office at the regular meeting in the month of July immediately following election and the President's term shall continue until assumption of office by the next President at the regular meeting in the following July.

Duties and Responsibilities

- 2) The President shall exercise the powers and shall perform the duties and functions as specified herein:
 - a) Preside at all Board meetings, ensuring that such meetings are conducted efficiently and in accordance with the *San Francisco Sunshine Ordinance* (Administrative Code, Chapter 67), and the *Ralph M. Brown Act* (California Government Code Section 54950 et seq.), & policies of the Board;
 - b) Recommend to the Board the creation of task forces or ad hoc committees of the Board, and the appointment of members and a chair to each standing committee, ad hoc committee, and task force. Recommendations concerning membership and chairs of standing committees are generally to be made by the President at the Board meeting following the meeting at which the President is elected;
 - c) Authenticate by his or her signature when necessary, or when required by law, all documents authorized by the Board;
 - d) Call special meetings. (Special meetings may be called by the President, and they must be called by the President upon the written request of a majority of the members of the Board or authorization by majority of the Board at a prior meeting. This provision must be implemented in a manner consistent with applicable open meeting laws);
 - e) In situations that call for a spokesperson to speak on behalf of the SFHSS, consult with the Executive Director and determine whether the President, Executive Director, or other individual should serve as spokesperson in the situation in question;
 - f) Review the agenda of each Board meeting with the Executive Director prior to the meeting;
 - g) Be available to assist committee chairs in carrying out their duties; and
 - h) Be available to assist the Executive Director in the orientation process for new Board members.

History

- 3) These terms of reference were adopted by the Board on February 22, 2007 and amended on April 9, 2015. Further amended on February 14, 2019.

Review: The Board shall review these terms of reference at least every three years.

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103: SFHSS VICE PRESIDENT OF THE BOARD TERMS OF REFERENCE

Introduction

- 1) Unless otherwise agreed by the Board, at its regular meeting in June of each year, the Board shall elect one Board member to serve as Vice President. The Vice President so elected shall take office at the regular meeting in the month of July immediately following election and the Vice President's term shall continue until assumption of office by the next Vice President at the regular meeting in the following July.

Duties and Responsibilities

- 2) The Vice-President shall assume the duties of the President when the President is absent, or when the President shall designate the Vice-President to act. In the event of death, resignation, removal from office or permanent disability of the President, the Vice-President shall temporarily act for the President until such time as an election can be held to elect a new President.

History

- 3) These terms of reference were adopted by the Board on February 22, 2007 and amended on April 9, 2015. Further amended on February 14, 2019.

Review

- 4) These terms of reference shall be reviewed by the Board at least every three years.

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104: SFHSS EXECUTIVE DIRECTOR TERMS OF REFERENCE

Introduction

- 1) The Executive Director shall hold office at the pleasure of the Board and shall be responsible to the Board as a Board, but not to any individual member or committee thereof. [Charter §12.201]
- 2) The Executive Director shall provide leadership for the SFHSS in implementing programs necessary to achieve the mission, goals and objectives established by the Board; and shall manage the day-to-day affairs of SFHSS in accordance with the Charter.
- 3) The Executive Director is the executive ultimately responsible for the entire operations of SFHSS. The Executive Director shall ensure proper delegation of duties to senior management and staff so as to maximize the efficiency and effectiveness of SFHSS resources.
- 4) The Executive Director shall provide support to the Board and its committees in establishing all policies of the Board including identifying and analyzing issues requiring Board policy, and providing policy options and clear, well-supported policy recommendations for consideration by the Board or its committees.
- 5) In addition to having operational responsibility for SFHSS, the Executive Director is responsible for assisting and supporting the Board and its standing committees in carrying out the duties and responsibilities set out in their respective terms of reference.

Duties & Responsibilities

Governance

- 6) The Executive Director shall assist the Board in its governance function by:
 - a) Recommending terms of reference and other policies to ensure appropriate governance practices;
 - b) Coordinating new Board member education and training and additional education within budget limitation in accordance with the Board Education Policy and Board Education Plan; and
 - c) Coordinating Board member travel within budget limitations.

Benefit Administration and Operations

- 7) The Executive Director shall direct and oversee all administrative and operational activities of the SFHSS including, but not limited to:
 - a) Developing and implementing all policies necessary to ensure effective administration of member benefits and reporting to the Board, and directing administrative staff involved in the delivery of service to plan members and in the operations of the SFHSS;
 - b) Developing and recommending a strategic plan to the Board;

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- c) Developing an annual operating budget, as well as applicable departmental budgets, and presenting them to the Board for approval as part of the City's budget process;
- d) Ensuring a system of operational risk management is in place, which addresses, among other things, sound records, data management and security;
- e) Ensuring prudent fiscal management, oversight, and reporting of SFHSS operations;
- f) Negotiating and executing agreements, and authorizing payments related to the administration of SFHSS and the appointment of all service providers, consistent with the operating budget and internal SFHSS controls;
- g) Ensuring effective and timely communications with members and stakeholders on matters relating to SFHSS administration; and
- h) Representing the SFHSS at the Board of Supervisors and other City departments on the budget and other matters affecting the SFHSS.

Human Resources

- 8) Consistent with the City's Administrative Code, applicable civil service rules, the operating budget, and collective bargaining agreements, the Executive Director shall hire, direct, supervise and, when appropriate, may terminate senior executives of the SFHSS, and shall oversee the hiring, management, and termination of staff. The Executive Director shall manage the employee grievance process relating to SFHSS staff in accordance with the City Charter, Administrative Code, and the collective bargaining agreements; and shall inform the Board of any issues as appropriate.
- 9) The Executive Director shall ensure ongoing assessment of SFHSS human resource needs and the development of appropriate human resource programs and procedures, including succession planning and coordination with other City departments as necessary.

Legislation and Litigation

- 10) The Executive Director shall carry out the following duties with the advice of legal counsel as necessary:
 - a) Monitor trends regarding legislation that may have a significant impact on SFHSS;
 - b) Report to the Board on any legislative proposals that could significantly affect the SFHSS, and recommend whether the Board should take any action;
 - c) Manage and coordinate, with legal counsel, all legal proceedings involving SFHSS;
 - d) Provide recommendations to the Board concerning member appeals, settlement or other legal action involving SFHSS;
 - e) Make recommendations or proposals to the Board on a proactive basis regarding Charter amendments that are consistent with the Mission of the SFHSS; and

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- f) Recommend to the Board that obsolete provisions of the Administrative Code be eliminated, or that various provisions of the Administrative Code be amended to reflect Charter amendments and/or new or revised State legislation.

Service Providers

- 11) The Executive Director shall:
 - a) Initiate and conduct the solicitations for contracts, and shall apprise the board of information regarding the selection process;
 - b) Negotiate and execute all agreements approved in connection with service providers/vendors;
 - c) Appoint those service providers for which the Board has delegated appointing authority to the Executive Director, in accordance with the Service Provider/Vendor Selection Policy or other Board action; and
 - d) Regularly monitor the performance of all service providers, and report regularly to the Board on such monitoring efforts.

Monitoring and Reporting

- 12) The Executive Director shall ensure that monitoring and control mechanisms are in place to ensure that policies and procedures are properly implemented, and that the operations of the SFHSS are effective.
- 13) The Executive Director shall provide the Board with relevant, appropriate and timely information to enable it to properly carry out its oversight responsibilities. Furthermore, the Executive Director shall apprise the Board in a timely manner of all significant issues, problems, or developments pertaining to SFHSS, and provide recommended courses of action as appropriate.

History

- 14) These terms of reference were adopted by the Board on February 22, 2007 and amended on April 9, 2015. Further amended on February 14, 2019.

Review

- 15) The Board shall review these terms of reference at least every three years.

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105: SFHSS BUDGET AND FINANCE COMMITTEE TERMS OF REFERENCE

Introduction

- 1) The Budget and Finance Committee has been established by the Board to assist the Board in the financial oversight of the SFHSS, including oversight of all audits of the SFHSS and the budgeting process. These financial oversight duties may be performed as a committee of the whole.

Composition

- 2) The Budget and Finance Committee shall be comprised of three Board members, including the Committee Chair, all of whom shall be appointed by the Board, upon the recommendation of the President.
- 3) The Executive Director shall designate a staff member to provide administrative support to the Budget and Finance Committee.

Operational Rules

- 4) The Budget and Finance Committee shall adhere to the following operational rules:
 - a) The presence of a majority shall constitute a quorum;
 - b) All actions of the Budget and Finance Committee shall be by a vote of the majority of the members present at a meeting of the Finance Committee, provided a quorum is present;
 - c) To be effective, all actions of the Budget and Finance Committee shall be approved by the Board;
 - d) The Budget and Finance Committee shall meet at least annually, or more often if it deems necessary.
- 5) The Budget and Finance Committee may establish other operational rules, procedures, calendars and agendas for the Committee, as necessary, provided they are consistent with the Charter and City ordinances, and the policies of the Board.
- 6) The Budget and Finance Committee shall periodically review its terms of reference, and advise the Governance Committee with respect to modifications, as appropriate.

Duties and Responsibilities

Audits and Examinations

- 7) The Budget and Finance Committee shall:
 - a) Provide clear direction to SFHSS that the external financial auditor is accountable to share a report to the Board;
 - b) Receive presentations from management or the external financial auditor regarding the annual audited financial statements, review any responses by management, and recommend any appropriate actions to the Board;

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- c) Provide the appropriate forum to review and comment on finalized management letters submitted by the financial auditor, review management's responses thereto, and provide recommendations to the Board, as appropriate; and
- d) Provide the appropriate forum for handling all policy-related matters with respect to audits, examinations, investigations or inquiries by any appropriate local, state or federal agencies in conjunction with the Executive Director and SFHSS staff.

Annual Budgeting Process

- 8) The Budget and Finance Committee shall:
 - a) Review the annual Administrative Budget and the Healthcare Sustainability Fund Budget of the SFHSS and all requested modifications and supplements thereto;
 - b) Recommend the Administrative Budget and the Healthcare Sustainability Fund Budgets to the Board for approval; and
 - c) Monitor SFHSS budget variance reports on a quarterly basis and recommend appropriate action to the Board and Executive Director, if necessary.

Other

- 9) The Budget and Finance Committee shall:
 - a) Review any significant changes in accounting practices or policies that may impact SFHSS' financial status;
 - b) Report regularly to the Board on its activities; and
 - c) Perform any other duties assigned by the Board.

History

- 10) These terms of reference were adopted by the Board on February 22, 2007 and amended on April 9, 2015. Further amended on February 14, 2019.

Review

- 11) The Board shall review these terms of reference at least every three years.

106: SFHSS GOVERNANCE COMMITTEE TERMS OF REFERENCE

Introduction

- 1) The Governance Committee has been established by the Board to assist the Board in:
 - a) Developing, overseeing, and implementing the governance policies and practices of the Board and its committees;
 - b) Coordinating the performance evaluations of the Board and the Executive Director
- 2) The Governance Committee shall be comprised of three Board members, including the committee chair, all of whom shall be appointed by the Board, upon the recommendation of the President.
- 3) The Executive Director shall designate a staff member to provide administrative support to the Governance Committee.

Operational Rules

- 4) The Governance Committee shall adhere to the following operational rules:
 - a) The presence of a majority shall constitute a quorum;
 - b) All actions of the Governance Committee shall be by a vote of the majority of the members present at a meeting of the Committee, provided a quorum is present;
 - c) All actions of the Governance Committee shall be approved by the Board to be effective, unless otherwise provided herein; and
 - d) The Governance Committee shall meet at least annually.
- 5) The Governance Committee shall establish other operational rules, procedures, calendars and agendas for the Committee, as necessary, provided they are consistent with the Charter, and City ordinances, and Board policies.

Duties and Responsibilities

- 6) The Governance Committee shall:
 - a) In consultation with the Executive Director, develop and recommend to the Board terms of reference for the:
 - i) Board;
 - ii) Committees of the Board;
 - iii) President and Vice President of the Board; and
 - iv) Executive Director.

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- b) Periodically recommend to the Board such amendments to the terms of reference as may be necessary or advisable;
- c) Recommend to the Board any modifications to the committee structure of the Board (i.e. the addition or elimination of any committees);
- d) Review, develop and recommend to the Board for approval, new governance policies as may be necessary, and review existing governance policies in accordance with the schedule for review established within each policy;
- e) Recommend to the Board a Board Education Plan and updates thereto;
- f) Co-ordinate the implementation of the annual Board performance evaluation policy, including approving and amending as necessary any surveys or similar forms used in the evaluation;
- g) Co-ordinate the implementation of the annual Executive Director performance evaluation policy. The Committee shall recommend to the Board the criteria to be used in evaluating the performance of the Executive Director, but shall have the authority to approve minor amendments as necessary to any surveys or similar instruments used to perform the evaluation;
- h) Monitor compliance with governance-related policies, rules, and legislation; and address any alleged violations;
- i) Report regularly to the Board on its activities; and
- j) At the request of the Board, undertake such other governance-related initiatives as may be necessary or desirable to contribute to the success of SFHSS.

History

These terms of reference were adopted by the Board on February 22, 2007 amended on April 9, 2015. Further amended on February 14, 2019.

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201: SFHSS BOARD OPERATIONS POLICY

Purpose

- 1) This Board Operations Policy is intended to set out the manner in which the Board shall conduct its business, and includes guidelines addressing, among other things, the appointment of officers, the establishment of committees, and the conduct of meetings.

Policy Guidelines

Board Composition

- 2) The Board shall, in accordance with Charter Section 12.200, consist of seven members: one member of the Board of Supervisors appointed by the President of the Board of Supervisors, two members to be appointed by the Mayor, and three members elected from the active and retired members of the SFHSS from among their number. [Charter § 12.200]
- 3) The two members appointed by the Mayor shall be appointed in accordance with the requirements set forth in Charter Section 3.100 and Charter Sections 12.100 –12.103. [Charter § 12.200]
- 4) One member appointed by the Controller and confirmed by a 2/3 vote of the Board per Charter Section 12.200. If the Board fails to calendar the Controller's nomination for consideration at a meeting to occur not later than 60 days after receipt of the Controller's written notice of nomination, the Controller's nominee shall be deemed approved.
- 5) The term of office of each member, except the member of the Board of Supervisors, shall be five years.
- 6) A vacancy on the Board appointed by the Mayor shall be filled by the Mayor. A vacancy in an elective office on the Board shall be filled by a special election within 90 days after the vacancy occurs unless a regular election is to be held within six months after such vacancy shall have occurred. [Charter Section 12.200] A vacancy in the Controller's appointed position shall be filled by the Controller and confirmed by the Board.

Election of President and Vice President

- 7) There shall be a President and Vice President of the Board each of whom shall be a Board member. [SFHSS Membership Rules and Regulations, A3]
- 8) At its regular meeting in June of each year, the Board shall elect one Board member to serve as President and one Board member to serve as Vice President. The President and Vice President shall take office at the regular meeting in the month of July immediately following election and their terms shall continue until assumption of office by the next President and Vice President at the regular meeting in the following July. [SFHSS Membership Rules and Regulations, A3(a)]

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- 9) In electing a President and Vice-President, it is expected that, at a minimum, the following criteria will be considered:
 - a) Demonstrated leadership abilities;
 - b) Committee and committee chairperson experience; and
 - c) Time availability.
- 10) If an officer vacates his office prior to the end of his term, an election shall be held at the next regular meeting of the Board to select a new officer, who shall take office immediately upon election and shall hold office for the unexpired term. Notwithstanding the foregoing, so long as there is no President, the Vice President shall act as President until a new President is elected and takes office. [SFHSS Membership Rules and Regulations, A3(b)]
- 11) Neither President nor Vice President may hold such office for more than two consecutive one-year terms. This two-term limit shall not include service for any unexpired term pursuant to paragraph 9 herein. [SFHSS Membership Rules and Regulations, A3(c)]

Board Committees

- 12) Based on the recommendations of the President, the Board shall:
 - a) Approve the establishment of standing and ad hoc committees; and
 - b) Annually approve the members and chairs of standing and ad hoc committees.
- 13) The standing committees of the Board shall be as follows:
 - a) Budget and Finance Committee
 - b) Governance Committee
- 14) The Governance Committee shall be responsible for recommending to the Board terms of reference for each standing committee of the Board.
- 15) Committees shall be comprised of not more than three Board members, one of whom shall be the committee chair.
- 16) In the event of a vacancy on any standing or ad hoc committee, the President shall appoint a replacement to hold office for the balance of the unexpired term.
- 17) The term of office for chairs of standing committees shall be one year. No chair of a standing committee may hold such office for more than two consecutive one-year terms. This two-term limit shall not include service for any unexpired term as set forth in paragraph 16 above.
- 18) Members and chairs of ad hoc committees shall serve until the dissolution of the committee, or until the Board determines otherwise.

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- 19) In the absence of a committee chair, the committee chair may designate in advance another committee member to act as chair for a particular meeting, failing which the remaining committee members shall designate one of themselves to act as chair for such meeting.
- 20) The Executive Director shall designate a staff member to provide administrative support to each committee.

Meetings of the Board and Committees

- 21) The time and location of Board meetings shall be as follows:
 - a) Regular meetings of the Board shall be held at 1:00 p.m. on the second Thursday of the month at City Hall room 416, San Francisco, or at such other time or place as the Board, at a prior regular meeting, may designate. In the event this day is a holiday, the meeting shall be held on the third Thursday, unless otherwise determined by the Board. [SFHSS Membership Rules and Regulations, A1(a)]
 - b) Special meetings of the Board may be called at any time by the President or by a majority of the Board. However, special meetings of the Board for closed sessions with legal counsel may precede or follow the regular meeting of the Board. [SFHSS Membership Rules and Regulations, A1(b)]
- 22) All meetings shall be open and public, and all persons shall be permitted to attend any meetings of the Board. Notwithstanding the foregoing, the Board may meet in closed session when authorized by the Ralph M. Brown Act of the State of California (the "Brown Act"), the San Francisco Sunshine Ordinance, Chapter 67 of the San Francisco Administrative Code, and Section 4.104(2) of the Charter. [SFHSS Membership Rules and Regulations, A1(c)]

Committee Meetings

- 23) Standing committees shall meet at times and places agreed to by the committee. Ad hoc committees shall meet as required.
- 24) If possible, committee meetings shall take place at City Hall, San Francisco. To assist committee members in planning ahead to attend meetings, each standing committee shall, if feasible, establish an annual forward agenda or meeting schedule.

Teleconferencing

- 25) Board members may not participate by teleconference in Board or committee meetings, except as provided for by law.
- 26) Advisors and other vendors may participate by teleconference at Board and committee meetings to the extent permitted by law.

Calendar, Meeting Materials, Minutes

- 27) The agenda for Board and committee meetings shall be prepared by the Executive Director and, if time permits, reviewed and approved by the President or committee chair respectively. Board and committee members may request that the Executive Director, President, or

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committee chair calendar any item for a Board or committee meeting, and such requests may be made at or outside a Board or committee meeting. The Executive Director, President, and committee chairs shall make a good faith effort to ensure all such requests are calendared within a reasonable period of time.

- 28) Consent agendas may be used to address items that staff considers to be routine and non-controversial. The consent agenda may be approved by one motion if no member of the Board or public wishes to comment or ask questions about any item on the consent agenda. If comment or discussion on any item is desired by anyone, the item will be removed from the consent agenda and will be considered separately by the Board.
- 29) The Board shall receive an advance calendar and the related meeting materials no later than the Friday preceding the next scheduled meeting.
- 30) Only items that have been calendared will be heard by the Board at any meeting. The Board may consider emergency items provided they have been noticed in writing at least 24 hours in advance of the Board meeting, consistent with the Ralph M. Brown Act.
- 31) A request that a calendared item be heard out of order shall be presented at the start of the meeting to the President. The President shall decide if the request shall be granted based on the reason for the request.
- 32) All calendared matters to be postponed shall be announced at the start of the meeting. During the course of a meeting any Board member or any interested party may request postponement of an action. The President shall approve or reject any request to postpone an action being considered by the Board at its meeting, subject to the discretion of the full Board.
- 33) With respect to minutes:
 - a) The Secretary to the Board shall record in the minutes the time and place of each Board and committee meeting, the names of the Board members present, all official acts of the Board or committee, and the votes of the members; and
 - b) The minutes shall be written and presented for correction and approval within a reasonable time. The minutes, or a true copy thereof, shall be certified by the Board Secretary.

Resolutions

- 34) The term "resolution" shall mean any action of the Board which prescribes or defines in written form a Board policy or decision.
- 35) The Board shall enact and adopt resolutions as follows:
 - a) At any regular or special Board meeting, any Board member may move for the adoption of a resolution which may be stated orally or in writing;
 - b) The Executive Director shall be responsible for performing, or causing to be performed, all necessary research and analysis to support resolutions prior to their adoption by the Board;

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- c) Prior to adoption, the proposed resolution shall be prepared by the Executive Director in proper format and the Executive Director may, if necessary, forward the resolution to the City Attorney's Office for approval as to format and legality. The proposed resolution shall thereafter be presented to the Board for action; and
- d) An adopted resolution shall be signed and dated by the President and the Executive Director.
- 36) All adopted resolutions shall be numbered in orderly sequence and shall be retained in the office of the Executive Director. The resolutions shall be readily accessible to members of the SFHSS and the public-at-large.
- 37) The Executive Director shall notify the Board of any legislative or court action which would require the rescinding, amending, or modifying a Board resolution.

Quorum, Rules of Order, and Voting

- 38) The presence of a majority of the members of an appointive Board, commission or other unit of government shall constitute a quorum for the transaction of business by such body. Unless otherwise required by the Charter, the affirmative vote of a majority of the members shall be required for the approval of any matter, except that the Operations Policy or Membership Rules may provide that, with respect to matters of procedure, the body may act by the affirmative vote of a majority of the members present, so long as the members present constitute a quorum. [Charter Section 4.104.]
- 39) The majority of the members of each committee shall constitute a quorum, and committees may act by a majority of the members present at a committee meeting provided, however, that a quorum is in attendance.
- 40) Board and committee members may not vote by proxy and must be present at a meeting in order to vote.
- 41) Except as otherwise provided in this Operations Policy, Robert's Rules of Order, in its latest revision, shall guide the Board as to rules of order in the event of a dispute among Board members.
- 42) When a Board member desires to address the Board, the member shall seek recognition by addressing the presiding officer. When recognized, the Board member shall proceed to speak, confining his remarks to the question before the Board. No discussion shall take place until a resolution or motion has been moved and seconded, or until a calendared item has been introduced. [SFHSS Membership Rules and Regulations, A6]
- 43) The Board may take action only upon a motion by a Board member, which has been seconded by another Board member.
- 44) Each member of the Board present at a regular or special meeting must vote "yes" or "no" when a question is put, unless excused from voting by a motion adopted by a majority of the members present. [Charter Section 4.104]
- 45) Tie votes shall be handled as follows:

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- a) A tie vote on an affirmative motion shall be deemed to be a failure to adopt such motion, and the matter or request before the Board is denied; and
- b) A tie vote on a negative motion shall be deemed to be a failure to adopt such motion, but the matter or request remains before the Board for action.
- 46) Nothing in this policy shall prohibit the President or a committee chair from making or seconding a motion, voting on a motion, and otherwise participating as a Board member.
- 47) A motion to reconsider a Board action can only be proposed by a Board member who voted with the prevailing side, However, a Board member who is not eligible to move to reconsider may briefly state their reasons for reconsideration. If the Board does not consent to hear the matter, the request is denied, and the previous action is final.
- 48) Requests for rulings on moot or hypothetical questions will not be permitted by the Board.

Attendance

- 49) Except in the event of a notified absence (defined below), each member of the Board is expected to attend each regular or special meeting of the Board and each meeting of any committees on which they serve. The Commission Secretary shall maintain a record of members' attendance.
- 50) A Board member's absence shall constitute a notified absence where the Board member, in advance of the meeting, informs the Commission Secretary that the member will be absent. An absence due to unforeseen circumstances such as illness or emergency shall also qualify as a notified absence where the member reports such absence to one of the above-mentioned parties as soon as reasonably possible. The Commission Secretary shall record as non-notified all absences involving neither advance notice nor unforeseen circumstances.
- 51) The Commission Secretary shall report all instances of non-notified absences as well as any instance of three consecutive absences of a member from Board or committee meetings in a fiscal year to the member's appointing authority.
- 52) At the end of each fiscal year, the Commission Secretary shall submit a written report to the appointing authorities of the Board detailing each Board member's attendance at all meetings of the Board and its committees for that fiscal year.

Public Comment

- 53) Before taking a vote on any action item, the Board shall ask for public comment. Each speaker shall be limited to three (3) minutes of comments with respect to each action item. This rule may be waived at the discretion of the presiding officer, or by vote of a majority of the Board members present. Board Secretary may be asked to time each speaker and to notify such speaker when the time limit has expired. Notwithstanding the foregoing, when a large number of speakers wish to comment on a particular action item, a reasonable overall time limit may be placed on public comment for such action item, and each speaker may thereby be limited to a period of comment that is less than **three minutes**. [SFHSS Membership Rules and Regulations, A5]

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- 54) Speakers who wish to make public comment may be requested to fill out speaker cards in advance provided, however, that a speaker may nevertheless choose to remain anonymous. [SFHSS Membership Rules and Regulations, A5]
- 55) Each speaker's comments must be pertinent to the item under consideration by the Board. The presiding officer of the meeting shall be the sole judge of such pertinence and may limit comments to the extent they do not pertain to the item under consideration or are duplicative of points made by previous speakers. Members of the Board need not respond after each speaker's comments. [SFHSS Membership Rules and Regulations, A5]
- 56) Members of the public may address the Board on any matter within the Board's jurisdiction during the "Other Business" item on the agenda. No formal action shall be taken on any matter raised during such agenda item unless such action is permitted under the Brown Act and the Sunshine Ordinance. [SFHSS Membership Rules and Regulations, A5]
- 57) If an agenda item is continued from one meeting to another, any member of the public who commented on such item at the initial meeting need not be permitted to comment on such item at the next meeting. This rule shall not apply, however, if the agenda item is modified in any manner after the initial meeting. [SFHSS Membership Rules and Regulations, A5]
- 58) Members of the public who disrupt a meeting by making noise, speaking out of turn, or otherwise refusing to comply with these Rules shall be given warning and an opportunity to correct their behavior. Thereafter, the Board may take action to have any such member(s) removed from the meeting. [SFHSS Membership Rules and Regulations, A5]

Policy Review

- 59) The Board shall review this policy at least every three years to ensure that it remains relevant and appropriate.

Policy History

- 60) This policy was adopted by the Board on February 22, 2007 and amended on April 9, 2015. Further amended on February 14, 2019.

202: SFHSS BOARD EDUCATION POLICY

Policy Objectives

- 1) The Board recognizes that Board members come to the Board with varying levels of knowledge and experience in the health and other employee benefits areas, and that all Board members can benefit from a formal Board education program. Furthermore, a well-designed Board education program will benefit SFHSS and its members and therefore justifies prudent budgeting for, and expenditure of SFHSS administrative funds and resources.
- 2) The objectives of this policy are to establish policy guidelines to help ensure:
 - a) That Board members have adequate opportunity and assistance to acquire the knowledge they need to effectively carry out their SFHSS Board member duties; and
 - b) That any expenditure of SFHSS funds or resources is prudent, cost-effective, and consistent with the best interests of the Board, SFHSS, and its beneficiaries.

Assumptions

- 3) This policy sets out various expectations concerning the efforts Board members should make to educate themselves on matters pertaining to health and other employee benefits. It is understood that any actual efforts undertaken by the Board or individual Board members shall be contingent on the availability of budget resources.
- 4) Though there may be limited resources available to fund attendance at educational conferences, a Board education policy is nevertheless necessary to define and guide other approaches to education available to the Board.
- 5) No single method of educating Board members is optimal – therefore, a Board education program should include a variety of educational methods and tools.

General Provisions

- 6) As fiduciaries, Board members are required to be knowledgeable of all matters concerning health and employee benefit policy and oversight. Accordingly, and within the constraints of available resources:
 - a) Board members agree to develop and maintain an adequate level of knowledge and understanding of relevant issues pertaining to SFHSS oversight and policy-setting throughout their terms on the Board; and
 - b) Board members agree to pursue appropriate education across a range of employee-benefit related areas, including:
 - i) Governance and fiduciary duty;
 - ii) Health and welfare plan design;

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- iii) Funding of health and welfare plans;
 - iv) Actuarial science;
 - v) Benefits administration; and
 - vi) Regulatory and legal environment of SFHSS.
- 7) In addition to technical knowledge, the Board recognizes that the Board training program should provide Board members with an understanding of the environment in which SFHSS operates, including the SFHSS's relationship to the Board of Supervisors, the employers participating in the SFHSS, and other departments within the City.
- 8) The Board considers the following types of vehicles to be appropriate for training its Board members and encourages Board members to take advantage of them, where budget resources permit:
- a) External conferences, seminars, workshops, roundtables, and similar events (henceforth referred to as conferences);
 - b) Meetings of associations or other similar bodies within the health and welfare industry;
 - c) In-house educational seminars or briefings by staff, City Administration, Board service providers, or other special advisors;
 - d) Relevant periodicals, journals, textbooks, or similar materials; and
 - e) Electronic media including webinars and pod casts.
- 9) Where budget resources permit, the Executive Director shall, on an ongoing basis, identify appropriate educational opportunities and include details of such through electronic means to Board members and in Board meeting packages for Board members' consideration. Board members are also encouraged to suggest educational programs that may provide value to the Board. Conferences requiring overnight lodging or other significant travel-related expenses should include an average of at least 5 hours of substantive educational content per day.
- 10) Board members shall attempt to meet the following minimum goals, provided sufficient budget resources are available:
- a) To secure, over time, a useful level of understanding in each of the topic areas listed in paragraph 6b above herein;
 - b) To attend at least one conference annually, which includes at least 5 hours of substantive educational content per day of the conference; (Recommended conferences are listed in Appendix 1 of this policy)
 - c) Regularly attend on-line educational events, e.g. webinars, that may be identified as being relevant to the Board; and

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- d) Participate in any in-house educational seminars or briefings that may be organized from time to time.
- 11) Board members shall annually complete the City training program on the Sunshine Ordinance and any other training programs mandated by the City. Attendance at such programs will be documented and reported to the Board Secretary on an annual basis.

Education Plan

- 12) The Board shall adopt a Board Education Plan covering a 1-3-year period and shall update the Plan as necessary.
- 13) The Board Education Plan may set out the education goals of the Board, with key topics to be covered over time by the Board and individual board members and shall cover both external and in-house education efforts. The Plan shall include a tentative schedule of topics to be addressed and associated timing.

Orientation Program

- 14) A formal orientation program, covering the general topic areas outlined in paragraphs 6b and 7 above, will be developed by the Executive Director for new Board members. The aim of the orientation program will be to ensure that new Board members are in a position to contribute fully to Board and committee deliberations, and effectively carry out their duties as soon as possible after joining the Board.
- 15) As part of the orientation process, new Board members shall, within 45 days of their election or appointment to the Board, be provided one or more general orientation sessions, during which they shall:
 - a) Be briefed by the Executive Director on the history, background, and structure of SFHSS;
 - b) Be oriented by the Executive Director and President on current issues before the Board;
 - c) Be provided an overview of the current health plans and benefits, and the benefit and funding policies of the Board, and how all such plans, benefits, and policies have evolved over time;
 - d) Be introduced to members of senior management;
 - e) Be provided a tour of SFHSS offices;
 - f) Be briefed on their fiduciary duties, conflict of interest guidelines, *The Brown Act*, the *Sunshine Ordinance* and other pertinent legislation; and
 - g) Be provided with:
 - i) A Board Member Reference Manual (the contents of which are listed in Appendix 2 of this policy);
 - ii) A listing of recommended educational programs; and

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- iii) Other relevant information and documentation deemed appropriate by the Executive Director.
- 16) Within 30 days of being appointed or elected to the Board or leaving the Board, Board members must complete a *Statement of Economic Interest and any other disclosure forms required by law*. The Board Secretary shall provide new Board members with any necessary assistance. Thereafter, Board members shall complete, and file said disclosure forms on an annual basis or consistent with the requirements of applicable laws.
- 17) As part of the orientation process, the Executive Director shall also make available a series of in-house education seminars for the benefit of new Board members, generally within 4 months of their election or appointment to the Board. Seminars will be designed and scheduled in consultation with the Board member(s) in question. Although intended for new Board members, any Board member may attend. The seminars will cover, at a minimum, basic health and welfare-related topics including health plan design, actuarial topics, SFHSS operations, legislation, and trust/fiduciary law.
- 18) The Executive Director shall review and update the Board Reference Manual as needed. A master copy of the Board Member Reference Manual will be available for use by Board members at the SFHSS offices.

Continuing Education – In-House Education Seminars

- 19) Annually, the Executive Director shall, after seeking Board input, identify at least two (2) topics of relevance to the Board, and shall organize one or more in-house educational sessions on these topics. Such sessions may be appended to regular Board or committee meetings or be organized as stand-alone sessions.

Attendance at Conferences & Association Meetings

- 20) Approval for attendance and reimbursement of travel expenses in connection with educational conferences or association meetings will be in accordance with the provisions set out in the SFHSS Board Travel Policy.

Reporting

- 21) Board members shall inform the Executive Director, for information purposes, of all health and welfare-related conferences attended, whether funded by SFHSS or not.
- 22) Attendees shall complete a brief written assessment of the quality and relevance of each conference attended (see Conference Attendance Form). The Executive Director shall review these assessments and update the list of recommended conferences as appropriate.
- 23) Upon returning from a conference, attendees may report to the Board on information or knowledge attained at the conference for the benefit of Board members who did not attend.
- 24) On an annual basis, the Board Secretary shall submit a report to the Board on the educational activities of the Board completed in the prior year. At a minimum, the report will summarize the implementation of the Board Education Plan including for example:

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- a) Attendance by Board members at conferences during the year;
- b) Webinars made available to Board members;
- c) Education sessions held during Board meetings;
- d) Special in-house educational sessions held during the year; and
- e) Other educational activities undertaken during the year.

Policy Review

- 25) The Board shall review this policy every year to ensure that it remains relevant and appropriate.

Policy History

- 26) The Board adopted this policy on February 22, 2007 and amended it on April 9, 2015. Further amended on February 14, 2019.

APPENDIX 1

Suggested Conferences, Seminars and Webinars

The following associations or conference organizers have been found to provide informative educational conferences and webinars. Conferences typically also contain the five (5) hours of substantive educational content per day, as required by the Board's travel policy. Board members are encouraged to visit their websites as a first step in identifying potential conferences to attend.

International Foundation of Employee Benefit Plans

Organizes an annual conference and other conferences and seminars throughout the year

Contact:

P.O. Box 69
Brookfield, WI 53008-0069

(888) 334-3327

<http://www.ifebp.org/>

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APPENDIX 2

BOARD MEMBER REFERENCE MANUAL

A Board Member Reference Manual shall include the following materials:

- a) Most recent plan descriptions or member handbooks
- b) Most recent Annual Report
- c) Organizational chart
- d) Contact information for the Executive Director and Board members
- e) Listing of current committee assignments
- f) Relevant City charter provisions
- g) Terms of reference and Board policies
- h) Glossary of key health and welfare administration terms and definitions
- i) SFHSS Membership Rules and Regulations

APPENDIX 3

Travel Policy

Travel Authorization

- 1) Each Board member is generally limited to one seminar or conference requiring travel outside of San Francisco County and/or overnight lodging per fiscal year. No more than one conference per year may involve travel to a destination outside the United States.
- 2) As a general rule, Board members should incur only those expenses that a reasonable and prudent person would incur when traveling on official business.
- 3) Attendance by Board members at seminars and conferences requiring travel outside of San Francisco County and/or overnight lodging requires prior approval of the Board and is subject to the limits set out in paragraph 1.
- 4) Attendance by Board members at association meetings, due diligence visits or other Board business requiring travel outside of San Francisco County and/or overnight lodging also requires prior Board approval.
- 5) All requests for business travel require approval in advance by the Board. A travel authorization form must be completed by the requestor and signed by the President of the Board or designee.
 - a) Information required for authorization includes:
 - i) Dates of travel and location
 - ii) Business purpose of travel/training/conference
 - iii) Estimated expenses including, but not limited to, when applicable, registration fee, cost of air ticket, other transportation costs, and lodging must be itemized with details or any changes made by the Controller.
 - b) The authorization form must be forwarded to Chief Financial Officer (“CFO”) to approve the use of funds and confirm all City requirements are met.
 - c) The CFO shall forward the authorization form to the Executive Director for final preauthorization approval.
- 6) The acceptance of any gifts which enable Board members to attend seminars and conferences requires prior approval of the Board in strict compliance with section 18944.2 of Fair Political Practices Commission Regulations.
- 7) Review and approval of educational travel will depend on the cost, substance and quality of the seminar or conference. As a general rule, travel to a conference or seminar outside of San Francisco County and/or requiring overnight lodging should only be approved if the conference/seminar agenda contains an average of five (5) hours of substantive educational content per day. The Board may waive this requirement if the best interests of SFHSS would be served by such a waiver.

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- 8) The Board recognizes that Board members are often considered experts in their professional fields or as having considerable experience as a Board member. As such, they may often be asked to speak at conferences. While SFHSS encourages the exchange of professional information, it must be evident that such speaking engagements would provide value to SFHSS before attendance is authorized on SFHSS' behalf.

Cost of Administration

- 9) Travel expenses of Board members shall be direct costs of administration to SFHSS and may not be paid through third party contracts without express approval of the Board or the Executive Director. Board members shall comply with applicable requirements for expenses paid or reimbursed by third parties.

Authorized Expenses

- 10) Authorized travel expenses include lodging, transportation costs, registration or attendance fees, meals and other costs reasonably and necessarily incurred when the Board member is required to travel on official SFHSS Board business.

Limitation on Allowance of Time and Expenses

- 11) Allowance for time and expense shall not exceed that which is usual and reasonable as claimed by others to that precise destination. Normally when meeting, conference, or seminar agendas calendar substantive content prior to 9:30 a.m., travel and arrival the evening before is authorized. When substantive content continues after 5:00 p.m., lodging for that night is authorized. Reasonable additional expenses, e.g. lodging and per diem for extra days either before or after a conference, will be reimbursed if such extension results in lower overall trip costs.

Limitation on Car Rental

- 12) Normally, Board members shall be expected to use an airport shuttle service to metropolitan destinations unless it is more economical to rent a car, pay for parking, fuel, etc. Reimbursement of alternative modes of transportation will be limited to the cost of the airport shuttle service unless otherwise justified, e.g., for reasons of personal safety or scheduling conflicts. As the City is self-insured, auto insurance is not reimbursable.

Cancellation of Travel and Lodging Arrangements

- 13) Normally, Board members are responsible for timely cancellation of travel and lodging arrangements made on their behalf so that no costs will be incurred by SFHSS.

Transportation Expense In Lieu Of Airfare

- 14) Airfare should be booked for economy/coach class only. Air tickets must be purchased in advance to take advantage of the most economical fares available. If airline charges for checked luggage, only the cost of the first checked bag may be reimbursed.
- 15) Board members have the option of purchasing air tickets from a City approved vendor or on-line directly. If Board members choose to purchase air travel on-line directly, they must document and demonstrate this option is the most economical by obtaining a comparative quote from a City vendor for the travel dates.

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Lodging Expense

- 16) The most economical and practical accommodations available considering the purpose of the meeting, and other relevant factors will be reimbursed. For travel within the United States, the maximum reimbursement is the Federal per-diem General Services Administration (“GSA”) rate for lodging. To stay within the maximum rates, conference discount rates and “government rates” should be used whenever possible.
- 17) In situations where lodging at GSA rates are not available, or business circumstances require the Board members to stay in a hotel that exceeds the federal per diem rate, reimbursement will be allowed if justified by business need, the most economical and practical lodging rates can be demonstrated, and pre-approval by the President of the Board is obtained.

Filing Claims

- 18) Claims for reimbursement of travel expenses shall be submitted to SFHSS Finance staff within 30 days following completion of the travel for which such expenses are claimed.
- 19) Supporting documentation including, but not limited to, approved travel authorization forms, air or other itinerary, conference/meeting/workshop schedules and agendas, original itemized receipts, and proof of payment documents, must be submitted and itemized when filing travel claims.

Cash Advances

- 20) Cash advances will not be allowed unless specifically approved by the Board.

Expenses for Spouses

- 21) Expenses of travel companions, including spouses, are not reimbursable by SFHSS.

Appendix 4

Education Resource Page

❖ Health Care Learning Resources:

- The California Health Care Foundation [blog](#) page
- The California Health Care Foundation [events](#) page
- The California Health Care Foundation [media](#) page
- The California Health Care Foundation [resource center](#) page
- The California Health Care Foundation [topics](#) page
- The California Health Care Foundation [projects](#) page
- The California Health Care Foundation [collections](#) page
- The California Health Care Foundation [investment](#) page

❖ America's Health Insurance Plans Resources:

- America's Health Insurance Plans [issues](#) page
- American's Health Insurance Plans [research](#) page
- America's Health Insurance Plans [news](#) page
- America's Health Insurance Plans [resources](#) page
- America's Health Insurance Plans [events](#) page

❖ Kaiser Family Foundation [homepage](#)

- Kaiser Family Foundation [newsroom](#) page
- Kaiser Family Foundation [perspectives](#) page



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203: SFHSS BOARD PERFORMANCE EVALUATION POLICY

Objectives

- 1) The Board recognizes that annual Board evaluations have become an accepted best practice in the area of Board governance. Accordingly, in keeping with the Board's desire to reflect best practice in all of its operations, the Board has adopted this Board Performance Evaluation Policy.
- 2) The objective of this policy is to set out a process by which the Board may engage in periodic self-assessment for the purposes of continuously developing and improving its own effectiveness as a governing body.

Principles

- 3) The Board performance evaluation process should include the participation of all Board members and be consistent with the provisions of *The Sunshine Ordinance* and *The Brown Act*.²
- 4) Management input into the Board's performance may be highly beneficial to the evaluation process, provided Management is given whatever level of anonymity it desires in the process.
- 5) The scope of the Board performance evaluation and any resulting actions should be limited to the activities and decision-making practices of the Board and Board members. Separate policies or practices will be used to evaluate the performance of the Executive Director.

Guidelines:

Roles & Responsibilities

- 6) The Governance Committee shall be responsible for coordinating the implementation of this policy, including the approval of any survey forms or similar instruments to be used in the evaluation process, and the making of recommendations to the Board for addressing issues arising out of the evaluation.

Procedures:

Board Member Surveys

- 7) In about the fourth quarter of each fiscal year, the Governance Committee shall review any survey tools to be used in the evaluation process and make modifications as appropriate. Due to cost considerations, it is expected that the evaluation will normally be administered using a survey.
- 8) The purpose of any Board survey instrument shall be to provide Board members with a framework for reviewing the performance of the Board and for raising, in an anonymous manner, if desired, any concerns or suggestions Board members may have to improve the Board's performance. Survey forms may take any format deemed appropriate by the Governance Committee but must provide an opportunity for Board members to provide written comments or suggestions.

² The *San Francisco Sunshine Ordinance* and The Ralph M. Brown Act, California Government Code Sections 54950 et seq.

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- 9) In about the fourth quarter of each year, copies of any Board surveys to be used will be distributed to each Board member with instructions for completing and submitting the survey.
- 10) Board members are required to complete and submit the survey within 14 days of receiving it. The Governance Committee shall determine the method for distributing, submitting, and tabulating the Survey, e.g. mail, internet, etc. Any summary report of findings will display the findings in a confidential manner.

Management Input

- 11) The Executive Director shall have the option of providing input on the Board's performance from members of SFHSS Management or staff using the same survey instrument used by Board members. Alternatively, the Executive Director may develop a separate survey tailored for use by Management and staff and shall review the survey with the Governance Committee. Any such surveys shall provide opportunity for written comments and suggestions.
- 12) The Executive Director shall determine which members of SFHSS Management or staff shall be invited to complete a Board evaluation survey. Such surveys shall be completed and tabulated in a manner that ensures anonymity. To that end, the Executive Director shall invite as many members of Management and staff as is reasonable and appropriate.
- 13) The Executive Director shall approve the summary of Management's survey results prior to the results being shared with any member of the Board.

Reporting

- 14) Board and Management survey results shall be summarized by an independent party, to be determined by the Governance Committee, and reviewed by the Governance Committee. Based on the results, the Governance Committee shall develop Committee recommendations for the Board's consideration.
- 15) The Governance Committee Chair shall report to the Board on the discussions, conclusions, and any recommendations of the Governance Committee.
- 16) The Board's discussions and any actions arising out of the evaluation shall be summarized in the Board minutes.

Interviews

- 17) The Governance Committee may recommend to the Board that in certain years the above surveys be replaced or supplemented with personal interviews of Board members and Management by an independent party to obtain more detailed or robust results.

Policy Review

- 18) The Board shall review this policy at least once every three (3) years to ensure that it remains relevant and appropriate.

Policy History

- 19) The Board adopted this policy on February 22, 2007; amended it on April 9, 2015. Further amended on February 14, 2019.

204: SFHSS EXECUTIVE DIRECTOR PERFORMANCE EVALUATION POLICY

Background and Purpose

- 1) The Board believes that selecting, directing, and evaluating the SFHSS Executive Director is one of its most important responsibilities. In keeping with this responsibility, the Board has adopted this policy, which sets out an annual process to be followed in assessing the Executive Director's performance and communicating the results to the Executive Director.

Policy Guidelines

- 2) The Governance Committee shall be responsible for coordinating the Executive Director performance evaluation process.
- 3) The Governance Committee, in consultation with the Executive Director, shall develop the criteria to be used in performing the evaluation. Quantitative criteria shall have a weight of 65% within the overall evaluation and qualitative criteria shall have a weight of 35%.

Qualitative Criteria

- 4) Qualitative criteria will generally be evaluated using a survey instrument or similar tool, to be developed by the Governance Committee and refined over time, with input from the Board as appropriate. Assessments of qualitative criteria by Board members that correspond to above or below "Satisfactory Performance" must be accompanied by examples and comments or they will not be considered. In cases where such assessments were not accompanied by examples or comments, the party responsible for administering the survey shall follow-up with Board members and encourage them to provide such commentary.
- 5) All members of the Board are expected to complete the survey instruments or tools developed by the Governance Committee as part of the Executive Director's evaluation.

Quantitative Criteria

- 6) Quantitative criteria shall reflect the strategic plan and shall be developed and refined over time as SFHSS develops methods for obtaining any necessary data and developing meaningful measures of performance.
- 7) To the extent possible, the Governance Committee shall obtain the necessary information or data to assess the quantitative criteria from independent sources, e.g., from the financial auditor.

Timing & Process

- 8) In the fourth quarter of each calendar year, Board members shall be provided copies of an evaluation survey addressing qualitative criteria and will have two weeks to complete and return them. Accompanying the survey will be a report from the Executive Director containing the Executive Director's own assessment and any supporting information and documentation the Executive Director believes may be of value to the Board members in completing the survey.

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- 9) The Chair of the Governance Committee shall work with the Executive Director and other parties as necessary to gather and synthesize any data and information necessary to assess the objective criteria.
- 10) The Chair of the Governance Committee, with the assistance of the Board Secretary, shall ensure that all the information necessary to facilitate the evaluation of the Executive Director (quantitative and qualitative) is tabulated and summarized in a report, and will review the results with the Governance Committee. Any Board member input provided shall not be anonymous.
- 11) In closed session, the Chair of the Governance Committee shall present to the Board a summary of the evaluation results along with the Committee's findings and recommendations for Board discussion and approval. A summary of the evaluation will be placed in the Executive Director's personnel file.
- 12) The Executive Director shall be allowed to attend any meetings of the Board or its committees at which the Executive Director's performance is to be reviewed and discussed and the Executive Director shall have an opportunity to respond to any of the Board's findings prior to the Board completing its evaluation. Such meetings will be held in closed session, as provided for by applicable open meeting laws. If the Executive Director chooses not to attend the Board meeting at which the Board finalizes the Executive Director's performance evaluation, the Chair of the Governance Committee and the President of the Board shall subsequently meet with the Executive Director to review the Executive Director's evaluation.
- 13) Minor changes to the Executive Director Evaluation Survey may be made by the Governance Committee provided the survey continues to reflect the subjective evaluation criteria approved by the Board. Material changes to the Survey shall be reviewed with the Board.
- 14) The Governance Committee shall generally hold a mid-year review with the Executive Director to assess progress, adjust goals and objectives if necessary, and identify potential issues or concerns. The Governance Committee shall report the results of the mid-year review to the Board along with any recommended adjustments to the evaluation criteria.

Compensation and Bonuses

- 15) The Board annually shall review the Executive Director's compensation and consider changes that may be feasible under existing City policies or programs.

Policy Review

- 16) The Board shall review this policy at least every three years to ensure that it remains relevant and appropriate.

Policy History

- 17) This policy was adopted by the Board on February 22, 2007 and amended on April 9, 2015. Further amended on February 14, 2019.

**SFHSS Executive Director Performance Evaluation Survey
Qualitative Performance Measures – DRAFT 2018**

Introduction

As set out in the *Executive Director Performance Evaluation Policy*, all Board members are expected to complete this survey, which is designed to allow Board members to assess qualitative aspects of the Executive Director’s performance. The survey addresses the following five areas:

1. Leadership and Vision
2. Resource Management and Governance
3. Management of People
4. Collaboration and Communication
5. Client Service Focus

Rating Scale & Definitions:

This survey uses a five-point scale along with a sixth option of Unable to Assess. The scale is defined below:

Exceptional Performance – is significant overachievement of expectations. (5)

Above Expectations – is often beyond expectations. (4)

Performance Meets Expectations – consistently fulfills expectations. (3)

Performance Improvement Needed – is inconsistent performance, with expectations only partially achieved.

Deficiencies should be addressed in the performance appraisal. (2)

Unsatisfactory Performance – is the failure to achieve the majority of expectations. Deficiencies should be specifically addressed in the performance appraisal. (1)

Unable to Assess – this option may be selected if a board member is relatively new to the Board or feels he or she has not been sufficiently exposed to a particular aspect of the Executive Director’s performance to provide an accurate rating. When selecting any rating other than “Performance Meets Expectations” or “Unable to Assess” Board members shall provide written examples and comments to support their rating. Failure to do so shall result in the rating being excluded from the summary of results, and thus not factoring into the Executive Director’s evaluation.

Leadership and Vision

The Executive Director envisions future possibilities and articulates a clear and compelling vision that inspires the staff to achieve strategic goals and organizational results. Identifies and capitalizes on strategic and operational

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Fosters an environment of individual growth and professional development. Recognizes and utilizes the skills of others through delegation and clearly outlining performance expectations. Provides timely performance feedback and recognizes superior performance. Recruits, retains, mentors and effectively coaches a talented diverse staff. Maximizes organizational results and individual effectiveness by defining measures of success.

- Exceptional Performance Improvement Needed
 Above Expectations Unsatisfactory Performance
 Satisfactory Performance
 Unable to Assess

As evidenced by: (Provide examples or comments to support the rating):

Collaboration and Communication

Collaborates with key constituents to successfully achieve organizational goals. Proactively establishes relationships with employees, clients, partners, the City, and the community. Understands the needs of these individuals and shares information and knowledge to meet SFHSS objectives. Develops relationships that are built on confidence and trust. Seeks perspectives and opinions from others to ensure sound decision making that leads to understanding the strategic and operational direction of SFHSS. Clearly expresses ideas, orally and in writing, and demonstrates skill in actively listening and interacting with others. Adapts to varying and unexpected situations and is flexible in the approach to resolving organizational challenges. Ensures the Board is provided with all necessary and timely information and kept abreast of all-important developments.

- Exceptional Performance Improvement Needed
 Above Expectations Unsatisfactory Performance
 Satisfactory Performance
 Unable to Assess

As evidenced by: (Provide examples or comments to support the rating):

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205: SFHSS MONITORING AND REPORTING POLICY

Introduction

- 1) In carrying out its responsibility to monitor and oversee the operations of the SFHSS, the Board receives numerous reports on various topics, from different parties, and with different frequencies. While some of the reports are ad hoc in nature, many are routine. The Board has adopted this policy to help ensure that the system of routine reporting is clear and systematic and will evolve over time to continue to meet Board needs.

Policy Guidelines

- 2) The Board shall be provided the routine reports including, but not limited to, those outlined in Appendix 1 of this policy with the frequency set out in Appendix 1.
- 3) Requests by Board members for additional routine reports shall require Board approval and an amendment to Appendix 1 of this policy.

Policy Review

- 4) The Board shall review this policy at least once every three years to ensure that it remains relevant and appropriate.

Policy History

- 5) The Board adopted this policy on February 22, 2007 and amended it on April 9, 2015. Further amended on February 14, 2019.

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APPENDIX 1— Scheduled Board Reports:

Report Name	Frequency-Month of Report	Prepared By	Presented By	Description and Purpose of Report
<i>Governance Reports</i>				
1) Report to the Mayor	Annually	Executive Director	Executive Director	As required by Charter Section 4.103, the Board is required to file an annual report of its activities with the Mayor's office & Clerk of the Board of Supervisors.
2) Board Education Plan	Annually	Governance Committee	Chair of GC	Summarizes the education goals of the Board and tentative schedule/timing of topics to be addressed.
3) Report on Board Education	Annually	tbd	Chair GHRC	Summarizes the training and educational activities (both external and in-house) of the Board and individual Board members.
4) Board Performance Evaluation Report	Annually	tbd	Chair GHRC	Summarizes the results of the Board's self-evaluation process, including follow-up actions.
5) Executive Director Evaluation Report	Annually	Governance Committee	Chair of GC	Summarizes the results of the Executive Director Evaluation process.
<i>Investment Reports</i>				
6) <u>Investment Policy Compliance Report</u>	Annually-	CFO	tbd	An assessment of the extent to which the Board's investment policy statement complied during the prior year.
7) Investment Performance Report	Annually	CFO	tbd	Summarizes investment performance of the Health Service Trust Fund in the past year.

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<i>Benefits Administration and Member Services Reports</i>				
8) Member Services Review	Annually	tbd	tbd	An assessment of the adequacy of health care provided for members of the SFHSS, fee schedules, compensation paid for all services rendered, and the general affordability of the plans it administers.
9) Demographics Report	Annually	tbd	tbd	Review of the participation levels by members within the health plans.
10) County Survey Report	Annually	tbd	tbd	Summarizes results from a survey of the 10 largest counties in California that assessed the average contribution made by county employees to health benefit coverage.
<i>Funding and Accounting Reports</i>				
11) Audit Report	Annually	External Auditor	External Auditor	Review of annual audited financial statements and external auditor's management letter.
12) Report on Reserves	Quarterly	CFO	CFO	Summarizes the levels of the reserves.
<i>Operations and Risk Management Reports</i>				
13) Service Provider Review	Annually	Executive Director	Executive Director	An assessment of the performance of key service providers, including but not limited to insurance carriers and third-party administrators, relative to pre-established performance criteria.
14) Risk Management Report	Annually	Executive Director	Executive Director	Summarizes ongoing system of operational risk management.

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206: SFHSS BOARD COMMUNICATIONS POLICY

Introduction & Objectives

- 1) Effective, coordinated, and accurate communication by the Board and Board members is essential to ensuring compliance with fiduciary obligations and to achieving operational effectiveness. To help achieve this, the Board has adopted this policy to guide Board member communications. The policy is intended to:
 - a) Ensure efficient and effective communications among Board members, staff, service providers, and stakeholders;
 - b) Serve and protect the interests of plan members and beneficiaries through consistent and accurate communication; and
 - c) Maintain a reputation of professionalism and integrity.

Principles

- 2) The Board is most effective when it communicates as one body with a single voice.

Definitions

- 3) Throughout this policy, the term “communication” shall refer to all forms of communication including written, oral, or electronic communications.

Guidelines

Communication with Board Members and Staff

- 4) Board members shall communicate in a respectful, honest, and constructive manner during all Board and committee meetings, and in all interactions with staff, service providers and the public at large.
- 5) Only the Board or a committee may request information from staff or assign work to the Executive Director.

Public Communications

- 6) Public communications on the part of the Board or SFHSS shall generally occur through a spokesperson designated by the Board or the Executive Director respectively. The designated spokesperson for the Board shall normally be the President or the Executive Director. The Board expects that the President and Executive Director shall confer to determine which of them shall act as spokesperson on a case-by-case basis.
- 7) In carrying out their duties, spokesperson(s) shall:

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- a) Confer with the Executive Director, President, the Board, or City Attorney as appropriate prior to engaging in official communications;
 - b) Communicate only official positions of the Board, and not make unilateral commitments on the part of the Board; and
 - c) Report back to the Board on any communications undertaken in their capacity as spokesperson.
- 8) Board members who are not designated spokespersons, and who nevertheless wish to communicate publicly on matters relating to the SFHSS, shall take all reasonable steps to ensure that they communicate the policies, positions, and deliberations of the Board in a clear and accurate manner.
 - 9) As a courtesy, Board members are encouraged to apprise the President and the Executive Director of any public communications they may have concerning the SFHSS. At a minimum, however, Board members shall inform the Executive Director and the President or Vice-President of any communication they engage in that might reasonably be expected to result in media exposure for the SFHSS.
 - 10) Board members are strongly advised to review in advance with the President and the Executive Director any communications they intend to make or release publicly, and to make any modifications recommended by them regarding the accuracy of such communications.
 - 11) If any board member publicly communicates a personal opinion that is inconsistent with a policy or decision of the Board, they shall clearly disclose to their audience that they are expressing a personal opinion and that such opinion does not reflect the policies or decisions of the Board.
 - 12) If a Board member votes with the losing side on an issue, the member is expected to nevertheless respect and support the decision of the majority. Reconsideration of Board actions may occur consistent with the Board Operations Policy. The Board recognizes that some Board members must function in capacities other than that of a Board member and, as such, may believe they must express publicly their disagreement with a decision of the Board. In such instances, the Board expects that they shall do so in an open, constructive, and professional manner.

Communication with Members and Beneficiaries

- 13) The Board does not intend to unduly restrain communications by Board members with plan members and beneficiaries. The Board also recognizes that Board members are generally not qualified to communicate technical details concerning the SFHSS and its numerous benefit plans, and that providing inaccurate or incomplete information to members may cause confusion or harm.

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Accordingly, Board members shall exercise judgement and discretion whenever communicating with plan members and beneficiaries, and shall be aware of and comply with the following guidelines to protect the SFHSS, Board members, and, most importantly, plan members and beneficiaries:

- a) Board members may communicate general information or simple, factual, information to members and beneficiaries only where there is no risk of communicating inaccurate or conflicting information;
- b) Board members may not provide plan members or beneficiaries with education, advice, or technical information pertaining to the benefit provisions of SFHSS. Instead, Board members should refer such members or beneficiaries to the SFHSS website, the SFHSS Member Services Department, or the Executive Director, as appropriate;
- c) Board members who, in their capacity as members of the Board, wish to meet with groups of plan members, beneficiaries, or stakeholders, for the purposes of conducting a meeting, presentation, or similar exchange shall exercise discretion and may:
 - i) Inform the Executive Director and, when possible, arrange for an SFHSS staff person to be present at the meeting to help ensure all communications accurately reflect the policies, positions, or benefit provisions of SFHSS; or
 - ii) Provide the Executive Director copies of any written materials the Board member intends to distribute at the meeting.

External Communications – Service Providers

- 14) Board members agree to abide by the black-out period provisions pertaining to service providers as specified in the Service Provider Selection Policy.
- 15) Individual Board members shall not direct or otherwise assign work to service providers. Instead, all direction or requests to service providers shall occur at a Board or committee meeting or be channelled through the Executive Director. Furthermore, Board members shall not direct plan members to contact service providers directly. They should be directed to contact SFHSS staff.

Policy Review

- 16) This policy shall be reviewed by the Board at least every three years.

History

- 17) This policy was adopted by the Board on February 22, 2007 and amended on April 9, 2015. Further amended on February 14, 2019.

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207: SFHSS SERVICE PROVIDER AND VENDOR SELECTION POLICY

Purpose

- 1) The Service Provider/Vendor Selection Policy is intended to establish general guidelines by which service providers will be selected, evaluated, or terminated by SFHSS.

Roles and Responsibilities

- 2) The role of the Board with respect to the selection of service providers is to:
 - a) Establish appropriate policies to help ensure prudent and sound selection decisions are made including, but not limited to, providing input to management about broad policy directions or specific goals and guidelines, prior to the drafting of a Request for Proposals (“RFP”);
 - b) Monitor compliance with such policies;
 - c) Approve the award of a contract with the following primary service providers:
 - i) Actuary;
 - ii) Insurance carriers;
 - iii) Hearing officers or firms providing the services of hearing officers;
 - iv) Third party administrators retained for services in connection with non-charter benefits and with a contract value in excess of \$200,000 annually;
 - v) Information technology consultants retained for services with a value in excess of \$200,000;
 - vi) Medical Executive Director; and
 - vii) Other service providers, as may be determined by the Board.
- 3) The Executive Director shall be responsible for selecting service providers/vendors other than the above primary service providers, consistent with the operating budget and other applicable policies of the Board and the City and County of San Francisco, and for keeping the Board apprised of such appointments, when material.
- 4) Notwithstanding paragraph 3 above, if the Executive Director determines that specific circumstances suggest that it would be prudent for the Board to approve the award of a contract to a particular service provider that is not a primary service provider, the Executive Director may elect to submit a selected service provider to the Board for its approval.
- 5) The Executive Director and department personnel shall initiate and conduct the solicitation for contracts and shall apprise the SFHSS Board about the selection process.

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- 6) It is recognized and understood that the following services are provided or co-ordinated by various departments within the City:
 - a) Financial and operational audit services;
 - b) Custody services;
 - c) Legal services;
 - d) Investment management and advisory services; and
 - e) Information technology services.
- 7) The Executive Director shall be responsible for ensuring that all necessary search and due diligence activities are carried out, with assistance from external advisors or experts as required.

The Search Process

General Guidelines

- 8) The selection of all service providers shall be made in the best interests of SFHSS members and beneficiaries in keeping with the fiduciary responsibilities of the Board and staff and will be consistent with the policies of the SFHSS and the City and County of San Francisco.
- 9) The Board and the Executive Director shall make a good faith effort to retain and utilize the services of disadvantaged business enterprises, on a primary or sub-contract basis, when those services or products are provided consistent with the fiduciary responsibilities of the Board and staff.

Black-Out Periods

- 10) The Board shall initiate a “black-out period” when notified that SFHSS will initiate a search process resulting in the release of an RFP, Request for Qualifications (“RFQ”) or other formal solicitations for the selection of a primary service provider or the expansion of a relationship with an existing primary service provider.
- 11) Black-out periods will be instituted at a Board or committee meeting. Written notification will be issued to all Board members not present at said meeting. A black-out period may also be instituted between Board meetings at the discretion of a Board acting as a committee of the whole. The Executive Director shall provide written notification to all Board members of all black-out periods instituted between Board or committee meetings as soon as possible. Board members shall comply with the black-out period restrictions upon receipt of the Executive Director’s notification.
- 12) The initiation of a black-out period, and types of providers to which it applies, will be specified in the minutes of the Board meeting at which it was approved or ratified by the Board. Where it is not possible to specifically define the types of service providers to which a black-out period

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applies, Board members shall make good faith efforts to comply with the intent of the black-out period provisions by taking all reasonable efforts to determine if service providers they may communicate with are potential candidates in an SFHSS search process.

- 13) During black-out periods, Board members shall not communicate with service providers who may provide the types of services for which the solicitation is being issued, except during Board or committee meetings. Board members who need to communicate with such service providers for reasons unrelated to SFHSS business agree to disclose such need in writing to the Executive Director and the Board prior to undertaking such communications. Disclosure to the Board shall be made at a meeting of the Board. If time does not permit timely disclosure to the Board, the Board member shall then provide written disclosure of the intended communication to the President, or to the Vice President if the Board member in question is the President.
- 14) During black-out periods, service providers participating in or considering participating in an SFHSS search process shall not communicate with Board members except during Board or committee meetings. This requirement shall be included in all RFPs and RFQs issued by SFHSS. Any service provider found to be in violation of the black-out provision may be subject to disqualification from the search process by the Board.
- 15) Board members found to have knowingly violated the black-out provisions may be subject to any penalties or other actions of the Board as set out in the SFHSS Statement of Incompatible Activities or the Code of Conduct.
- 16) For black-out period provisions, communications include telephone conversations, letters, and e-mail.
- 17) A black-out period will cease when a successful bidder has been selected to a contract or agreement with SFHSS, enters signs into a contractual arrangement with HSS or the City and County of San Francisco, or the search process is otherwise ended by the Board.

Contracts

- 18) The Executive Director shall negotiate and execute all agreements approved in connection with service providers. In negotiating contracts or contract renewals, the Executive Director may seek the assistance of Board members as appropriate.
- 19) All contracts and similar arrangements for the engagement of service providers shall comply with applicable laws and regulations.
- 20) Annually, the Executive Director shall provide the Board a two-year budget which provides details on the types of services that SFHSS will be issuing solicitations for during that time period. The notice of the “black-out” will serve as notification that SFHSS has created an RFP or RFQ. The Board shall approve the award of the contract.

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Monitoring and Reporting

- 21) All service providers shall be subject to regular monitoring of performance and expenditures and periodic reviews, as appropriate, throughout the term of their contract. Criteria for review may include performance, staff satisfaction, competitiveness of fees, quality of reporting, and accuracy of assumptions and forecasts and adherence to budget.
- 22) The Executive Director shall report regularly to the Board on all monitoring efforts involving service providers, identifying any material issues or actions taken in a timely fashion.
- 23) All monitoring and reporting provisions contained in this policy serve as minimum requirements. If more stringent requirements are established within other policies of SFHSS, such requirements will prevail.
- 24) The Executive Director shall report to the Board any material failures by named service providers to comply with the terms of their contract.

Policy Review

- 25) The Board shall review this policy at least every three (3) years to ensure that it remains relevant and appropriate.

Policy History

- 26) The Board adopted this policy on February 22, 2007 and amended it on April 9, 2015. Further amended on February 14, 2019.

208: SFHSS STRATEGIC PLANNING POLICY

Introduction

- 1) Like every complex organization, SFHSS continually faces new challenges and opportunities, and has limited resources with which to address them. Organizational success requires that SFHSS have an effective planning process that allows it to set the strategic direction of the SFHSS, identify specific business priorities, effectively allocate resources to such priorities, and plan for their successful completion. The Board has established this Strategic Planning Policy to provide guidance to the SFHSS's planning process.

Objectives

- 2) The objectives of the Strategic Planning Policy are to:
 - a) Ensure SFHSS actively and systematically plans for the future needs of the SFHSS; and
 - b) Facilitate consensus by the Board and the Executive Director on the direction, needs, and priorities of the SFHSS.

Principles

- 3) An effective planning process should strike an appropriate balance between ensuring a systematic approach to planning, encouraging creativity in identifying business issues and solutions, and ensuring sufficient flexibility to respond to changing circumstances.

Policy Guidelines

Roles and Responsibilities

- 4) The Executive Director shall be responsible for:
 - a) Identifying risks, opportunities, and needs of the SFHSS;
 - b) Identifying and prioritizing business initiatives; and
 - c) Recommending a Strategic Plan to the Board for its consideration.
- 5) The Board shall be responsible for playing a policy and oversight role in the planning process, which will include:
 - a) Approving the Strategic Planning Policy and any amendments thereto;
 - b) Providing the Executive Director with input into the broad direction of the SFHSS and possible initiatives to be included in the Strategic Plan;

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- c) Approving the Strategic Plan and ensuring adequate resources are in place to successfully implement it; and
- d) Monitoring the implementation of the Strategic Plan.

The Annual Planning Process

- 6) In approximately the fourth quarter of each calendar year, the Executive Director shall present and discuss the following issues with the Board:
 - a) The status of the current year's Strategic Plan which can be in the form of the draft annual report;
 - b) Current business needs, risks, or opportunities of the SFHSS; and
 - c) A prioritized list of proposed business initiatives with supporting rationale.
- 7) On the basis of the above review and discussions, the Executive Director with input from senior staff, shall prepare a draft Strategic Plan. The Executive Director shall have discretion in determining the most effective or appropriate format for the Strategic Plan, but it is expected that the plan will generally include the following components:
 - a) The mission statement of SFHSS and any necessary detail or elaboration;
 - b) A discussion of current business needs, risks, and opportunities;
 - c) Proposed business initiatives accompanied by rationale and appropriate analysis, data, and parameters including for example:
 - i) Expected outcomes of each initiative;
 - ii) Timelines for completion;
 - iii) Assignment of responsibilities for implementation;
 - iv) Resource implications;
 - v) Risk analysis; and
 - vi) Criteria for assessing the success of the initiative.
- 8) In the first quarter of each year, the Executive Director shall present the draft Strategic Plan to the Board for its consideration and approval.
- 9) Should the Executive Director determine that changing circumstances will not allow the Executive Director to meet a particular parameter associated with a Strategic Plan initiative, the Board shall be informed in a timely manner

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Review of Strategic Plan Status

- 10) The Executive Director shall review the status of each initiative in the Strategic Plan mid-year.

Strategic Session

- 11) As a separate but complementary element of the SFHSS's strategic planning process, the Board shall strive to organize at least one strategic session annually to engage in informal strategic discussions and related education or information-sharing. The focus of such session may vary each year but should be a forward-looking attempt to identify and understand trends or issues that may affect the future of health care. The session should allow for more informal interaction among board members, senior staff and potentially service providers or stakeholders. The strategic session may, but need not, result in specific initiatives for inclusion in the strategic plan.

Policy Review

- 12) The Board shall review this policy at least every three years to ensure that it remains relevant and appropriate.

Policy History

- 13) The Board adopted this policy on February 22, 2007 and amended it on April 9, 2015. Further amended on February 14, 2019.

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209: SFHSS TRUST FUND INVESTMENT POLICY

1.0 Background and Purposes

The City and County of San Francisco Health Service System ("HSS") was established through a City Charter amendment in 1937. City and County of San Francisco Charter ("City Charter")

Section A8.420. The City Charter Section 12.203 (see also City Charter Sections A8.423 and A8.428) established the Health Service System Fund ("Fund"). It provides:

The Health Service System fund shall be a trust fund administered by the Health Service Board in accordance with the provisions of this Charter solely for the benefit of the active and retired members of the Health Service System and the covered dependents. The City and County, School District and Community College District shall each contribute to the Health Service System Fund amounts sufficient to efficiently administer the Health Service System.

The Fund was established to facilitate the contributions and disbursements of the System, while also providing a funding source to ensure payments could be made if disbursements exceeded contributions for a period of time. See also City Charter A8.429, which provides as follows:

1. The health service board shall determine and certify to the controller the amount to be paid monthly by the members of the system to the health service system fund for the purposes of the system hereby created. The controller shall deduct said sums from the compensation of the members and shall deposit the same with the treasurer of the City and County to the credit of the health service system fund.

Such deductions shall not be deemed to be a reduction of compensation under any provision of this Charter.

2. The health service board shall have control of the administration and investment of the health service system fund, provided that all investments shall be of the character legal for insurance companies in California. Disbursements from the fund shall be made only upon audit by the controller and the controller shall have and exercise the accounting and auditing powers over the health service system fund which are vested in him by this Charter with respect to all other municipal boards, officers, and commissions

3. The purpose of this Investment Policy Statement is to set forth the objectives and constraints on

the Fund, and to establish appropriate guidelines and options for investing Fund assets. This statement is intended to incorporate sufficient flexibility to accommodate current and future economic and market conditions, as well as any changes in applicable statutory and regulatory requirements.

2.0 Definitions

- Recordkeeper: The term "Recordkeeper" shall mean the individual, entity, or organization responsible for maintaining and updating the information regarding the Fund balance, reserves, and other duties necessary to maintain the proper accounting of the Fund.
- Custodian: The term "Custodian" shall mean the custodian bank which holds the assets of the Fund.
- Investment Advisor: The term "Investment Advisor" shall mean a registered investment advisor who the Board may, but is not required to, retain to provide advice or other assistance to the Board with respect to the Fund investments and administration.

3.0 Statement of Investment Goals and Objectives

The purchase and administration of health and other benefits necessitates significant cash inflows and outflows in the Fund. Therefore, the primary objective of the Fund is to act as a temporary repository of assets before such assets are disbursed. The Fund's investment objectives include the following:

- Safety: To maintain safety of the principal and ensure that investment of the Fund assets are undertaken in a manner that seeks to preserve capital, while complying with relevant statutory requirements;
- Liquidity: To maintain sufficient liquidity to enable the HSS to meet all obligations when due;
- Cost Control: To control costs of administering the Fund and managing Fund Assets while assuring sufficient flexibility to meet future needs; and
- Return on Investment: To enable the Fund to maximize return within reasonable and prudent levels of risk consistent with investment objectives with low risk assets.

4.0 Fiduciary Standards

The San Francisco Health Service Board ("Board") is the fiduciary for the Fund and is charged with governing the Fund. As Trustees of the Fund, Board members are fiduciaries. As fiduciaries, the Board members must comply with applicable fiduciary standards including, but not limited to, the prudent person standard set forth in: California Constitution Article 16, Section 17(c); the California Uniform Prudent Investor Act ("UPIA"); and California Government Code Section 53600.3.

In addition, the HSS Board Governance Manual requires that the Board shall be responsible for approval and subsequent review of a written policy statement, ensuring responsible management thereof, compliance with the policy, and ongoing review of investment performance.

5.0 Use of Investment Advisor and Other Professionals

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The Board may retain a registered investment advisor ("Investment Advisor") to provide advice and other assistance to the Board to help it fulfill its obligations with respect to the Fund investments and administration. The Investment Advisor's services and the fees charged for those services must be set out in a written agreement with the Board under which the Investment Advisor acknowledges that it is a co-fiduciary with respect to the Fund.

6.0 Allocation of Responsibilities

6.1. Board's Responsibilities

As set forth in Charter Section A8.429, the Board "shall have control of the administration and investment of the health service system fund, provided that all investments shall be of the character

legal for insurance companies in California." Charter Section A8.429; see also California Insurance Code sections 1170-1202 and Government Code sections 53600 et seq. In performing

this function, the Board shall:

- Prepare and maintain a written investment policy statement (e.g., this Statement), review the statement periodically, and make changes to such statement, as appropriate from time to time;
- Designate certain investments that may be made under the Fund;
- Establish and implement a disciplined process for selecting, monitoring, and retaining or terminating investments; and
- Take appropriate action if investment objectives are not met or investment policies or guidelines are not followed.

The Board shall also:

- Select and monitor the performance and fees of the Investment Advisor, if retained, a Recordkeeper, and other providers for the Fund as it deems appropriate; and
- Review all agreements between the Fund and service providers to ensure adherence to statutory requirements.

6.2. Controller Responsibilities

The Controller shall have the responsibilities set out by law, which shall include:

- Deducting the requisite amounts, as determined by the Board, from the members' compensation;
- Depositing such amounts with the Treasurer; and
- Exercising accounting and auditing powers over the Fund.

6.3. Custodian's Responsibilities

The Custodian is responsible for safekeeping the Fund's assets. The duties and responsibilities of the Custodian include:

- Maintaining possession of the Fund assets (directly or through a sub-custodian);

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- Collecting all income and dividends owed to the Fund;
- Settling all transactions (buy-sell orders);
- Valuing the Fund's holdings; and
- Providing monthly reports that detail transactions, cash flows, securities held, their current value, and other portfolio statistics in accordance with the California Government Code.

6.4. Investment Advisor's Responsibilities

The Investment Advisor, if retained, shall provide investment advice to the Board concerning the

investment of Fund assets consistent with the investment objectives, policies, and constraints included in this Investment Policy Statement, as amended from time to time. The Investment Advisor's responsibilities include:

- Assisting in the creation, review, and revision of a written investment policy statement (e.g. this Statement);
- Assisting in the establishment and implementation of a disciplined process for selecting, monitoring, and retaining or terminating investments;
- Providing independent and unbiased information;
- Assisting in investment option mapping where deemed appropriate;
- Assisting in the control of investment expenses, including helping to negotiate investment, Recordkeeper, and other service provider fees;
- Reporting annual investment performance results to enable the Board to evaluate investment performance in light of existing goals and objectives; and
- Performing such other services for the Fund as agreed to by the Board and the Investment Advisor from time to time.

6.5. Treasurer's Responsibilities

The Treasurer shall be responsible for those funds required for daily cash flow and for all additional funds delegated to the Treasurer for investment which exceed the amounts necessary for daily cash flows and reserves.

7.0 Investment Options

The Board, with the assistance of the Investment Advisor, if retained, shall consider several factors

when determining the most prudent course of investing the Fund's assets in excess of the amount

needed for daily cash flow and reserves, including:

- The goals and constraints of the Fund (see Section 3.0 Statement of Objectives above);
- The investment's track record;
- The performance as compared to an appropriate benchmark;
- The investment risk;

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- The investment strategy, any changes in investment strategy, and adherence to stated strategy over time;
 - The fees and expenses associated with the investment;
 - Qualitative characteristics, including, but not limited to, management strategy, strategy of assets under management, turnover, and recent portfolio activity in view of the current market conditions; and
 - Such other information as the Board and Investment Advisor deem appropriate.
- In selecting investment options for the Fund, the Board shall comply with California Government Code, Section 53600, and may not invest in any investments not specifically authorized by California Government Code, Section 53600. In general, Section 53600 limits local agency investment funds to high quality, fixed income securities with maturities of less than five years. Securities with a maturity of greater than five years require approval by the Board of Supervisors.

For example, permitted securities include:

- Obligations of the United States Government ("Treasuries"), federal agencies, municipalities, and negotiable Certificates of Deposits ("CD") are allowed with a maximum maturity of five years.
 - Medium-term corporate bonds ("A" or better) and asset-backed securities with a maximum maturity of five years;
 - Repurchase agreements with a maximum maturity of one year;
 - Commercial paper with a maximum maturity of 270 days; and
 - Bankers' acceptances notes with a maximum maturity of 180 days.
- Prohibited securities include, but are not limited to, Commercial Mortgage Backed Securities, high yield bonds, convertibles, non-United States denominated investment grade bonds, emerging market debt, equities, commodities, real estate, hedge funds, and private equity. Additional guidelines on permissible and prohibited investments are set forth in Government Code sections 536001 to 53610 attached hereto.

The following options currently satisfy the above factors:

1. Investing assets in the City and County of San Francisco's Treasury Pool2 (which complies with California Government Code 53600). Investment in the City and County of San Francisco's Treasury Pool also meets Section 16 of the Health Service Board's Governance Manual (referenced above). If adopted, the Board shall receive quarterly written updates

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on the performance of the Treasury Pool and an annual update from Treasurer and Tax Collector staff;

2. Investing assets with external investment managers to run a portfolio that will comply with the California Government Code; or

3. Making direct purchases of investment assets.

Investment options #2 and #3 above are limited to investing the fund balance less: (i) obligations (funds required for daily cash flow); and (ii) reserves.

8.0 Monitoring of Investments

The Board shall decide the most appropriate options for investment of the Fund, pursuant to Section 7.0 above and shall monitor the investment options on an ongoing quarterly basis. No less than every three (3) years the Board shall review the Fund's performance in detail. Material changes in market conditions or changes to the investment team managing the Fund assets or the team's strategy would require a more timely review.

9.0 Investment Policy Review

The Board shall review this Investment Policy Statement periodically, but not less than every three (3) years, to determine whether the investment objectives are still relevant. It is not expected that this Statement will change frequently. In particular, short-term changes in the financial markets should not require adjustments to this Investment Policy Statement.

1. This Investment Policy Statement acknowledges that Section 53600 of the Government Code is more restrictive than the California Insurance Code, however, both must be considered when investing Fund assets.

2. The City and County of San Francisco's Treasury Pool's investment priorities of safety, liquidity, and return should align with the objectives of the HSS Fund. The Treasury Pool's Investment Policy is reviewed and monitored by the Treasury Oversight Committee pursuant to City and County Administrative Code Section 10.80-1.

10.0 Effective Date

The policy is effective immediately upon Board approval. This Investment Policy Statement shall guide the Board and the Investment Advisor, if retained, and shall remain in effect until amended by the Board. Nothing contained in this Statement shall provide to any participant or beneficiary the right to challenge the terms of this Investment Policy Statement. Subject to relevant statutory requirements, the Board shall have full discretion as to how it selects and monitors the investments and the application of this Investment Policy Statement to any specific situation.

¹ The City and County of San Francisco's Treasury Pool's investment priorities of safety, liquidity, and return align with the objectives of the SFHSS Fund. The Treasury Pools Investment Policy is reviewed and monitored by the Treasury Oversight Committee pursuant to City and County Administrative Code Section 10.80-1.

210: SFHSS CONTINGENCY RESERVE POLICY

Policy Objectives

It is prudent for an administrator of a self-funded benefit program to establish a Contingency Reserve, otherwise known as excess loss reserve, to absorb financial strain brought about by adverse claims experience. A Contingency Reserve is funding reserved to cover the risk of claims in excess of expected claims target.

Independent of the ability of a self-funded benefit plan to access external dollars to fund adverse experience, it is prudent and sound to consider implementing a Contingency Reserve. It allows the Plan Sponsor to establish a budget based on a predetermined funding level and maintain that structure regardless of claims experience level.

In the case of the City Plan it is additionally important to recognize that there is no reinsurance for this self-funded program. Full responsibility remains with the Trust to absorb potential excess cost over expected cost. This makes it essential that the Trust hold an excess loss reserve.

Contingency Reserve Policy

This policy standardizes the **Contingency Reserve** setting methodology for the Health Service System's (HSS) self-funded health plans. The purpose of the Contingency Reserve is to establish reserve funds that are available in the event that claims are in excess of target costs. The Contingency Reserve policy is specific to HSS's self-funded healthcare plans:

- The Self-Funded PPO City Plan
- The Self-Funded Employee Dental PPO Plan
- The Flex-Funded HMO Plan (non-capitated costs)

The methods specified in this document will be applied for Contingency Reserve estimation as of June 30 each year, at the end of each fiscal year

Definitions

Contingency Reserve: Any actuarial estimate is based upon the information available at a point in time and is subject to unforeseen and random events. At any point in time, estimated reserves may be higher or lower than required. Future funding projections will generate revenue that may be higher or lower than actual experience. There are multiple factors that impact the eventual experience of the self-funded health plans. The range of plausible results around the best estimate rates would consider:

- Random variation from expected claims
- Credibility of the experience
- Fluctuations in large claims experience

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- Vendor processing stability
- Changes in COBRA enrollment
- Catastrophic events and whether to make allowance or not

The Contingency Reserve is intended to immunize against such adverse experience.

Large Claims Reserve: a subset of the Contingency Reserve. The Contingency Reserve accounts for all claims over the projected claims target level. The Large Claims Reserve accounts for all large claims over a certain threshold. Since all large claims over the threshold are also over the projected claims target level, they are already being accounted for in the Contingency Reserve.

Contingency Reserve Methodology

To establish the Contingency Reserve(s), linear regression is used, specifically:

- The City and County of San Francisco's third-party administrator(s) provide either 36 or 48 months of claim data which the actuarial consultant firm summarizes by incurred and paid period. This data is separate for each line of coverage (medical, pharmacy and dental) and for each plan.
- These amounts are converted to a per employee per month (PEPM) basis and linear regression is performed on the monthly PEPM values.
- The regression data is used to determine the predicted monthly values and the corresponding monthly variances, as well as the predicted annual claims per employee per year (PEPY) and corresponding variance PEPY.
- Using the predicted claims PEPY and variance PEPY, the expected value is calculated at a particular level of confidence. This is done by using the normal distribution. For our analysis, we use three levels of potential excess cost; confidence levels of 95%, 97% and 99%.
- The gross Contingency Reserve is the difference between the cost at a particular confidence level and the projected PEPY costs times the anticipated enrollment, plus a margin between 0% and 10%.
- The actuarial consultant firm presents the analysis at the three levels of confidence (95%, 97% and 99%) to the HS Board for final determination of the approved contingency reserve amount for each plan.

Policy History

The Board adopted this policy on March 12, 2008 and amended it on March 14, 2013. Amended on February 13, 2014.

Review

The Board shall review this policy at least every three years.

211: SFHSS SELF-FUNDED PLANS' STABILIZATION POLICY

Policy Objectives

The objective of a stabilization reserve is to spread any underwriting gains or losses into following year's premium calculation in an even-handed manner such that the Employers and membership are not subject to volatile year over year changes in premium.

Stabilization Policy

This policy standardizes the methodology that will be used to incorporate the impact of prior year revenue excess and shortfalls against projected expense in future self-funded plans' premium rate requirements. The purpose of a Stabilization Policy is to even out the premium fluctuations year-to-year.

The Health Service System's (SFHSS) self-funded health plans covered by this policy include:

- The Self-Funded PPO City Plan
- The Flex-Funded/Self-Funded HMO Plan(s)
- The Self-Funded Dental PPO

As described in the Methodology section below, a rolling three-year period will be used to reflect prior year revenue excess and shortfalls against projected expense in the City Plan. The methods specified in this document will be applied annually during the rate-setting process to plan year premium rates using the revenue excess or shortfall experienced during the prior plan years.

The actuarial consultant firm presents the recommendation and supporting analysis to the HS Board for approval of the stabilization reserve calculation each year during the rate setting process.

Definitions

Contingency Reserve: Any actuarial estimate is based upon the information available at a point in time and is subject to unforeseen and random events. At any point in time, estimated reserves may be higher or lower than required. Future funding projections will generate revenue that may be higher or lower than actual experience.

There are multiple factors that impact the eventual experience of the self-funded health plans. The range of plausible results around the best estimate rates would consider:

- Random variation from expected claims
- Credibility of the experience
- Fluctuations in large claims experience
- Vendor processing stability
- Changes in COBRA enrollment
- Catastrophic events and whether to make allowance or not

The contingency margin is intended to immunize against such adverse experience.

IBNR Reserve: Reserve for estimated claims that have been incurred by members but not yet processed, including unknown future developments on existing claims.

Methodology

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The self-funded plans' premium rates for plan year X will consist of the following five components:

- Estimated incurred claims cost for plan year X
- Estimated cost of administering the claims over plan year X
- Estimated cost of any fully insured products (i.e. EGWP premium) over plan year X
- Estimated change in the Contingency Reserve over plan year X
- Factor reflecting revenue excess or shortfall experience from prior plan years

The first three components of the self-funded plans' premium rates (incurred claims, administrative costs, and, if applicable, any fully insured premium) are common to the in-force premium rates. Unlike the change in IBNR (Incurred but not reported), which is implicitly included in the projection of incurred claims, the Contingency Reserve is added as a component of each plan's targeted year-end funding level. The anticipated change in the Contingency Reserve is factored into the rate requirements as the fourth component of the self-funded plans' premium rates.

The fifth component of self-funded plans' premium rates "Factor reflecting revenue excess or shortfall experience from prior plan years", is the focus of this policy.

The methodology used to determine the "Factor reflecting revenue excess or shortfall experience from prior plan years" varies by plan

The revenue excess or shortfall in any plan year will be determined by comparing the following two amounts:

- 1) Expected Revenue = Expected incurred claims + Expected administration costs + Expected fully insured premium (if applicable) + Expected change in Contingency Reserve

The expected revenue amount will be based on the per capita estimates for the plan year aggregated using actual plan year enrollment.

- 2) Actual Revenue = Actual incurred claims + Actual administration costs + Actual fully insured premium (if applicable) + Actual change in Contingency Reserve

The methodology described should be reviewed at a minimum every three years to confirm its continued appropriateness.

Example: The City Plan (UHC)

For plan year X, this component equates to one third of the cumulative difference between prior years' revenue and expense less prior years' release of this amount.

An illustration is provided below:

Revenue excess in year X-2 = \$90

Premium rates for plan year X includes an offset of \$30, i.e. one-third of \$90, thus leaving a balance of \$60

Revenue excess in year X-1 = \$90

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Premium rates for plan year X+1 includes an offset of \$50, i.e. one-third of the accumulation of \$150 ($(\$90 - \$30) + \$90 = \150), thus leaving a balance of \$100

Revenue shortfall in year X = $-\$70$

Premium rates for plan year X+2 includes an offset of \$10, i.e. one-third of the accumulation of \$30 ($(\$90 - \$30) + (\$90 - \$50) - \$70 = \30), thus leaving a balance of \$20

Allocation of cumulative revenue excess or shortfall across categories of membership
To develop the premium rate factor, allocation of the cumulative revenue excess or shortfall across categories of membership (employees/non-Medicare retirees/Medicare retirees) is proportional and is based on the aggregate of the projected claims costs, administration costs, fully insured premium costs (if applicable), and Contingency Reserve increase/decrease over the plan year in question.

An illustration is provided below:

The projected claims costs, administration costs, fully insured premium costs (if applicable), and Contingency Reserve increase/decrease over the plan year for the City Plan in year X are expected to be \$60 million and this is split across membership categories as follows:

Employees: \$20 million

Non-Medicare Retirees: \$10 million

There is also a cumulative revenue excess amount of \$6 million to be allocated across membership categories, the allocation in the calculation of premiums for plan year X would be as follows:

Employees: \$2 million

Non-Medicare Retirees: \$1 million Medicare Retirees: \$3 million

Policy History

The Board adopted this policy on March 12, 2008, amended it on March 14, 2013, amended it on February 13, 2014 and amended it again on January 8, 2015.

This policy has been applied to City Plan annually since 2007.

Review

The Board shall review this policy at least every three years.

212: SFHSS IBNR Reserve Policy and Methodology

Policy Objectives

Given the fact that there is a lag between the time period when a medical service is rendered to the time that a claim is fully settled in payment, it is prudent for a self-funded plan to set aside funds for an IBNR (Incurred But Not Reported) Reserve. An IBNR reserve, otherwise known as an operating reserve, is an estimate of the unpaid claims liability for runout claims. In order to accurately project the self-funded plan's outstanding claims liability, the HSB's actuary will estimate the cost of claims rendered but not yet paid based on past experience.

IBNR Reserve Policy

This policy standardizes the ***IBNR Reserve*** setting methodology for the Health Service System's (HSS) self-funded health plans. The IBNR Reserve policy is specific to the self funded

plans for which HSS maintains reserves, i.e. the following plans:

- The Self-Funded PPO City Plan
- The Self-Funded Employee PPO Dental Plan
- The Flex-Funded HMO Plan (non-capitated costs)

The methods specified in this document will be applied for IBNR Reserve estimation as of June 30th of each year at the end of each fiscal year.

Definitions

IBNR Reserve: Reserve(s) calculated to pay for the outstanding liability of estimated run-out claim costs that have been incurred before a given date but have not paid as of the given date.

Developmental Method: the method by which the IBNR liability is estimated based on claim run-out patterns which are assumed to remain stable over time.

Projection Method: the IBNR liability estimate produced by the Developmental Method is adjusted for months where data is considered non-credible using the Projection Method

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based on the change in costs per exposure unit over time. The IBNR liability is further adjusted to reflect actuarial assumptions related to a number of factors/contingencies which could impact reserve adequacy. Such factors/contingencies include: change in claim payment cycles, plan design, insurance carriers, large dollar claims, emerging claim trends, provider contract changes, seasonality, and other factors.

IBNR Reserve Methodology

The reserves at the end of each plan year will equate to the sum of the estimated future cost of incurred but not reported claims (**IBNR**) as of that date and the estimated cost of administering these claims.

The IBNR reserves will be based on the historical claims experience of each plan. An actuarial analysis of this experience will be completed to develop factors that are applied to paid claims data to estimate the potential run-out of these claims post-fiscal-year-end. Where plan specific claims data is deemed less than fully credible, additional normative claims data can be utilized to supplement the analysis performed.

HSB's actuarial consultant firm applies the Developmental Method and the Projection Method to set the IBNR Reserve(s).

The estimated cost of administering the run-out claims will reflect the terms and conditions of the plan administrator responsible for settling the relevant plan's claims.

The actuarial consultant firm presents IBNR Reserve recommendations and supporting analysis to the HS Board for approval.

Policy History

The Board adopted this policy on March 12, 2008 and amended it on March 14, 2013, and amended it again on February 13, 2014.

Review

The Board shall review this policy at least every three years.

SAN FRANCISCO

CHARTER AND ADMINISTRATIVE

CODE SECTIONS

APPLICABLE TO

THE SAN FRANCISCO

HEALTH SERVICE SYSTEM

(11/10/16 BOARD PRESENTATION)

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CHARTER SECTIONS

I. CHARTER SECTION 4.102 – BOARDS AND COMMISSIONS – POWERS AND DUTIES.

Unless otherwise provided in this Charter, each appointive board, commission or other unit of government of the executive branch of the City and County shall:

1. Formulate, evaluate and approve goals, objectives, plans and programs and set policies consistent with the overall objectives of the City and County, as established by the Mayor and the Board of Supervisors through the adoption of City legislation;

2. Develop and keep current an Annual Statement of Purpose outlining its areas of jurisdiction, authorities, purpose and goals, subject to review and approval by the Mayor and the Board of Supervisors;

3. After public hearing, approve applicable departmental budgets or any budget modifications or fund transfers requiring the approval of the Board of Supervisors, subject to the Mayor's final authority to initiate, prepare and submit the annual proposed budget on behalf of the executive branch and the Board of Supervisors' authority under Section 9.103;

4. Recommend to the Mayor for submission to the Board of Supervisors rates, fees and similar charges with respect to appropriate items coming within their respective jurisdictions;

5. Unless otherwise specifically provided, submit to the Mayor at least three qualified applicants, and if rejected, to make additional nominations in the same manner, for the position of department head, subject to appointment by the Mayor;

6. Remove a department head; the Mayor may recommend removal of a department head to the commission, and it shall be the commission's duty to act on the Mayor's recommendation by removing or retaining the department head within 30 days; failure to act on the Mayor's recommendation shall constitute official misconduct;

7. Conduct investigations into any aspect of governmental operations within its jurisdiction through the power of inquiry, and make recommendations to the Mayor or the Board of Supervisors;

8. Exercise such other powers and duties as shall be prescribed by the Board of Supervisors; and

9. Appoint an executive secretary to manage the affairs and operations of the board or commission.

In furtherance of the discharge of its responsibilities, an appointive board, commission or other unit of government may:

10. Hold hearings and take testimony; and

11. Retain temporary counsel for specific purposes, subject to the consent of the Mayor and the City Attorney.

Each board or commission, relative to the affairs of its own department, shall deal with administrative matters solely through the department head or his or her designees, and any dictation, suggestion or interference herein prohibited on the part of any member of a board or commission shall constitute official misconduct; provided, however, that nothing herein contained shall restrict the board or commission's powers of hearing and inquiry as provided in this Charter.

II. CHARTER SECTION 4.103 – BOARDS AND COMMISSIONS – ANNUAL REPORT.

As of the operative date of this Charter and until this requirement is changed by the Board of Supervisors, each board and commission of the City and County shall be required by ordinance to prepare an annual report describing its activities, and shall file such report with the Mayor and the Clerk of the Board of Supervisors. The Annual Report can be included in the Annual Statement of Purpose as provided for in Section 4.102(2).

III. CHARTER SECTION 4.103 – BOARDS AND COMMISSIONS – RULES AND REGULATIONS.

(a) Unless otherwise provided in this Charter, each appointive board, commission or other unit of government of the executive branch of the City and County shall:

1. Adopt rules and regulations consistent with this Charter and ordinances of the City and County. No rule or regulation shall be adopted, amended or repealed, without a public hearing. At least ten days' public notice shall be given for such public hearing. All such rules and regulations shall be filed with the Clerk of the Board of Supervisors.

2. Hold meetings open to the public and encourage the participation of interested persons. Except for the actions taken at closed sessions, any action taken at other than a public meeting shall be void. Closed sessions may be held in accordance with applicable state statutes and ordinances of the Board of Supervisors.

3. Keep a record of the proceedings of each regular or special meeting. Such record shall indicate how each member voted on each question. These records, except as may be limited by state law or ordinance, shall be available for public inspection.

(b) The presence of a majority of the members of an appointive board, commission or other unit of government shall constitute a quorum for the transaction of business by such body. The term "presence" shall include participation by teleconferencing or other electronic means as authorized by Government Code Section 54953(b) or any successor legislation after the Board of Supervisors has adopted an ordinance pursuant to subsection (c) allowing such participation when the member is physically unable to attend in person, as certified by a health care provider, due to the member's pregnancy, childbirth, or related condition. The Board of Supervisors may also, as part of a parental leave policy adopted pursuant to subsection (c), authorize a

member of a board or commission to participate in meetings by teleconferencing or other electronic means when the member is absent to care for his or her child after birth of the child, or after placement of the child with the member or the member's immediate family for adoption or foster care. Unless otherwise required by this Charter, the affirmative vote of a majority of the members shall be required for the approval of any matter, except that the rules and regulations of the body may provide that, with respect to matters of procedure the body may act by the affirmative vote of a majority of the members present, so long as the members present constitute a quorum. All appointive boards, commissions or other units of government shall act by a majority, two-thirds, three-fourths or other vote of all members. Each member present at a regular or special meeting shall vote "yes" or "no" when a question is put, unless excused from voting by a motion adopted by a majority of the members present.

(c) Notwithstanding the provisions of Charter Section 10.101, the Board of Supervisors shall provide by ordinance for parental leave policies for members of appointive boards, commissions or other units of government, including, but not limited to, authorization to participate in meetings by teleconferencing or other electronic means pursuant to subsection (b) and subject to the restrictions listed in that subsection.

(Amended by Proposition B, Approved 11/7/2006)

IV. CHARTER SECTION 12.200. – HEALTH SERVICE BOARD.

There shall be a Health Service Board which shall consist of seven members as follows: one member of the Board of Supervisors, to be appointed by the President of the Board of Supervisors; two members appointed by the Mayor pursuant to Section 3.100, one of whom shall be an individual who regularly consults in the health care field, and the other a doctor of medicine; one member nominated by the Controller and three members elected from the active and retired members of the System from among their

number. Elections shall be conducted by the Director of Elections in a manner prescribed by ordinance. Elected members need not reside within the City and County.

Not later than April 1, 2013 the Controller shall nominate a candidate for appointment to the Health Services Board for a two-year term commencing on May 15, 2013. The Controller shall transmit a written notice of nomination to the Health Services Board. The Controller's nominee shall be subject to the approval of the Health Services Board. If the Health Services Board fails to calendar the Controller's nomination for consideration at a meeting to occur not later than 60 days after receipt of the Controller's written notice of nomination, the Controller's nominee shall be deemed approved. All subsequent appointments of Controller's nominees shall be for a five-year term and be subject to the same procedure. The Controller's nominee may not vote on his or her successor.

The terms of Health Service Board members, other than the ex officio members, shall be five years, and shall expire on May 15 of each year, with the exception that the term of the Board member that begins in May 2011 shall be three (3) years, and shall expire in May 2014, and the term of the Board member that begins in May 2013 term shall be two (2) years, and shall expire in May 2015.

The appointee nominated by the Controller shall succeed the elected member whose term expires at 12:00 noon on May 15, 2013. In the event the elected member whose term expires on May 15, 2013, leaves the Board prior to that date, the Controller shall nominate a successor to fill the unexpired term according to the procedures set forth above.

A vacancy on the Board appointed by the Mayor shall be filled by the Mayor. A vacancy on the Board of an appointee nominated by the Controller shall be filled for the unexpired term according to the procedures set forth above for Controller's nominees. A vacancy in an elective office on the Board shall be filled by a special election within 90

days after the vacancy occurs unless a regular election is to be held within six months after such vacancy shall have occurred.

The Health Service Board shall:

1. Establish and maintain detailed historical costs for medical and hospital care and conduct an annual review of such costs;
2. Apply benefits without special favor or privilege;
3. Put such plans as provided for in Section A8.422 into effect and conduct and administer the same and contract therefor and use the funds of the System;
4. Make rules and regulations for the administration of business of the Health Service System, the granting of exemptions and the admission to the System of persons who are hereby made members, and such other officers and employees as may voluntarily become members with the approval of the Board; and
5. Receive, consider and, within 60 days after receipt, act upon any matter pertaining to the policies of, or appeals from, the Health Service System submitted to it in writing by any member or any person who has contracted to render medical care to the members.

Except as otherwise specifically provided, the Health Service Board shall have the powers and duties and shall be subject to the limitations of Charter Sections 4.102, 4.103 and 4.104.

Subject to the requirements of state law and the budgetary and fiscal provisions of the Charter, the Health Service Board may make provision for health or dental benefits for residents of the City and County of San Francisco as provided in Section A8.421.

(Amended November 2004; Proposition F, Approved 11/2/2010; Proposition C, Approved 11/8/2011)

V. CHARTER SECTION 12.201. – MEDICAL DIRECTOR AND HEALTH SERVICES ADMINISTRATOR.

The Health Service Board may appoint a full-time or part-time medical director. He or she shall hold office at its pleasure. The medical director shall be responsible to the Board as a board, but not to any individual member or committee thereof. The Health Service Board shall appoint a full-time administrator with experience in administering health plans or in comparable work, who shall hold office at the Health Service Board's pleasure. The Health Services administrator shall administer the Health Service System in accordance with the provisions of this Charter and the rules, regulations and policies of the Health Service Board. The Board and each committee of the Board shall confine its activities to policy matters and to matters coming before it as an appeals board. The Board shall prepare its rules, regulations and policies so that they are clear, definite and complete and so that they can be readily administered by the Health Services administrator.

(Amended November 2004)

VI. CHARTER SECTION 12.202. – MEMBERSHIP IN HEALTH SERVICE SYSTEM.

The members of the System shall consist of all officers and permanent employees of the City and County, the Unified School District, the Community College District, and such other officers, employees, dependents and retirees as provided by ordinance.

VII. CHARTER SECTION 12.203. – HEALTH SERVICE SYSTEM FUND.

The Health Service System fund shall be a trust fund administered by the Health Service Board in accordance with the provisions of this Charter solely for the benefit of the active and retired members of the Health Service System and their covered dependents. The City and County, School District and Community College District shall

each contribute to the Health Service System Fund amounts sufficient to efficiently administer the Health Service System.

VIII. CHARTER SECTION A8.420 – ESTABLISHMENT OF AND MEMBERSHIP IN HEALTH SERVICE SYSTEM

A health service system is hereby established. Said system shall be administered by the human resources department subject to the approval of the health service board. The members of the system shall consist of all permanent employees, which shall include officers of the City and County, of the San Francisco Unified School District, and of the Parking Authority of the City and County of San Francisco and such other employees as may be determined by ordinance, subject to such conditions and qualifications as the Board of Supervisors may impose, and such employees as may be determined by collective bargaining agreement. Any employee who adheres to the faith or teachings of any recognized religious sect, denomination or organization and, in accordance with its creed, tenets or principles, depends for healing upon prayers in the practice of religion shall be exempt from the system upon filing annually with the human resources department an affidavit stating such adherence and dependence and disclaiming any benefits under the system. The human resources department shall have the power to exempt any person whose compensation exceeds the amount deemed sufficient for self-coverage and any person who otherwise has provided for adequate medical care. Any claim or request for exemption denied by the human resources department may be appealed to the health services board.

IX. CHARTER SECTION A8.421 – ADOPTION OF PLANS FOR RESIDENTS

Subject to the requirements of state law and the budgetary and fiscal provisions of the Charter, the Health Service Board is authorized by a two-thirds vote of the entire membership of the Health Service Board to adopt a plan or plans or make other

provision for health or dental benefits for residents of the City and County of San Francisco. Such plan or plans shall not become effective until approved by an ordinance of the Board of Supervisors adopted by three-fourths of its members. Residents shall not by virtue of enrolling in such plan or plans become members of the Health Service System. The Health Service System Fund shall not be used to provide any benefits under this section. The Health Service Board shall adopt rules and regulations to administer this section.

The determinations made under this section, including but not limited to whether to adopt a plan or plans, what benefits to offer, determination of eligibility, and the fixing and allocation of the cost of any plan or plans, are within the sole discretion of the City and County and its officials.

(Amended November 2004)

X. CHARTER SECTION A8.422 – ADOPTION OF PLANS FOR MEMBERS

The board shall have power and it shall be its duty by a majority vote of the entire membership of the health service board to adopt a plan or plans for rendering medical care to members of the system, or for the indemnification of the cost of said care, or for obtaining and carrying insurance against such costs or for such care.

Such plan or plans as may be adopted, shall not become effective until approved by ordinance of the Board of Supervisors, adopted by three-fourths of its members.

The Board of Supervisors shall secure an actuarial report of the costs and effect of any proposed change in the benefits of the health service system or rates of contribution before enacting an ordinance or before voting to submit any proposed Charter amendment providing for such change.

(Amended November 2004; Proposition C, Approved 11/8/2011)

XI. CHARTER SECTION A8.423 – REVISION OF SCHEDULES AND COMPENSATION

In January of each year, or at such other time consistent with the Plan Year set by the health service board, or at such other time consistent with the Plan Year set by the Health Service Board, at a public hearing, the Health Service Board shall review and determine the adequacy of medical care provided for members of the system and the adequacy of fee schedules and the compensation paid for all services rendered and it may make such revisions therein as it deems equitable but such revisions shall not become effective until approved by ordinance of the Board of Supervisors adopted by three-fourths of its members.

Commencing in 1973, the Health Service Board shall, prior to the second Monday in January in each year, or at such other time consistent with the Plan Year set by the Health Service Board, conduct a survey of the 10 counties in the State of California, other than the City and County of San Francisco, having the largest populations to determine the average contribution made by each such county toward the providing of health care plans, exclusive of dental care, for each employee of such county. The Health Service Board may promulgate rules and regulations for the survey to allow for unavoidable gaps in survey data and to insure a consistent methodology from year to year. In accordance with said survey, the Health Service Board shall determine the average contribution made with respect to each employee by said 10 counties toward the health care plans provided for their employees and on or before the second Monday in January of each year, or at such other time consistent with the Plan Year set by the Health Service Board, the Health Service Board shall certify to the Board of Supervisors the amount of such average contribution. For the purposes of Section A8.428, the amount of such average contribution shall be "the average contribution."

The Health Service Board shall have the responsibility to obtain and disseminate information to its members with regard to plan benefits and costs thereof. All expenses in connection with obtaining and disseminating said information, the investment of such fund or funds as may be established, including travel and transportation costs, member wellness programs, actuarial expenses and expenses incurred to reduce health care costs, shall be borne by the system from reserves in the health service fund but only upon adoption of a resolution by the Health Service Board approving such expenses. (Amended November 2004; Proposition C, Approved 11/8/2011)

XII. CHARTER SECTION A8.424 – SPECIFICITY REQUIRED

Each plan for medical care shall make detailed and specific provision for the benefits to be provided thereunder and for the rates of contribution required to support the plan.

XIII. CHARTER SECTION A8.425 – PERSONS COVERED

Each plan may make provision for the participation in the benefits of the system by the dependents of members, retired City and County employees, temporary City and County employees, such other dependents of deceased and retired City and County employees as the Board of Supervisors may authorize by ordinance, teachers and other employees of the San Francisco Unified School District retired under the San Francisco City and County Employees' Retirement System and resigned employees of the City and County and resigned teachers and employees of the school district whose resignations occur after June 15, 1955, and within 30 days immediately prior to the date on which, but for their resignations, they would have become retired members of the said Retirement System, on whose relinquishment of retirement allowances as permitted by the Charter occurs after such date and resigned employees of the San Francisco Unified School District not otherwise included. A resigned employee or

teacher is one whose employment has terminated other than by retirement, discharge or death or who has relinquished retirement allowances. The purpose of empowering the health service board to make provision for the participation in the benefits of the system to the aforementioned resigned teachers and employees of the San Francisco Unified School District is to enable them, subject to the health service board's exercise of its power, to participate in the benefits of the system after transferring to the State Teachers' Retirement System from the San Francisco City and County Employees' Retirement System. The purpose of empowering the health service board to make provision for participation in the benefits of the system by the aforementioned resigned employees of the City and County and other resigned employees of San Francisco Unified School District is to permit the health service board to have power to treat them the same as it treats resigned teachers and employees of the San Francisco Unified School District.

As used in this section, and for the purpose of this section, the terms "City and County employees" and "employees of the City and County" shall include officers and employees of the Parking Authority of the City and County of San Francisco.

In addition to "the average contributions" in Subsection (b) of Section A8.428, the Board of Supervisors may provide by ordinance for additional funds from the City and County to pay the full cost of any plan for medical benefits adopted under Sections A8.422 or A8.423 for current members of the Board of Supervisors. The Board of Supervisors may also provide by ordinance for the continuation in any plan by former supervisors who agree to and do pay the full cost of such benefit.

(Amended March 2000)

XIV. CHARTER SECTION A8.426 – RIGHT OF SELECTION

No member of the health service system shall be required to accept the services or medical supplies of any physician (physician includes physicians and surgeons,

optometrists, dentists, chiroprodists and osteopathic and chiropractic practitioners licensed by California State Law and within the scope of their practice as defined by California State Law), person licensed to treat human diseases without the use of drugs, nurse, pharmacist or hospital selected by the health service board, but, subject to rules and regulations of that board, every member shall have the right to select, of his or her own choice, a duly licensed physician, as defined herein, person licensed to treat human diseases without the use of drugs, nurse, pharmacist, hospital or other agency of medical care as herein defined, who or which is made available through health service system plans; and the health service board shall make provision for the exercise of such selection; and is hereby expressly prohibited from entering into any exclusive contract for the rendering of said service.

A duly licensed physician, as defined herein, person licensed to treat human diseases without the use of drugs, nurse, pharmacist, hospital or other agency of medical care shall have the right to furnish such services or medical supplies at uniform rates of compensation to be fixed by the health service board.

(Amended by Proposition C, Approved 11/8/2011)

XV. CHARTER SECTION A8.427 – EFFECT OF OTHER CHARTER PROVISIONS

Except as otherwise specifically provided herein, all provisions of the Charter shall be fully applicable to the health service board, the health service system and its administrator, medical director and employees in the same manner that they apply to other boards, commissions, and departments of the City and County.

(Amended November 2004)

XVI. CHARTER SECTION A8.428 – HEALTH SERVICE SYSTEM TRUST FUND

There is hereby created a health service system trust fund. The costs of the health service system shall be borne by the members of the system and Retired

Persons, the City and County of San Francisco because of its members and Retired Persons, the Parking Authority of the City and County of San Francisco because of its members and Retired Persons, the San Francisco Unified School District because of its members and Retired Persons and the San Francisco Community College District because of its members and Retired Persons.

A. Definitions.

"Credited Service" means years of employment with the Employers or the former Redevelopment Agency of the City and County of San Francisco (the "Redevelopment Agency") or the Successor Agency to the Redevelopment Agency of the City and County of San Francisco (the "Successor Agency"), provided that for any employee of the Redevelopment Agency or Successor Agency, the employee became an employee of the Redevelopment Agency before September 1, 2010 and became an employee of the City and County without a break in service after January 31, 2012 and before March 1, 2015.

"Employers" as used in this section means the City and County of San Francisco ("City and County"), the San Francisco Unified School District ("School District") and/or the San Francisco Community College District ("Community College District"). Employers shall also include the Superior Court of California, County of San Francisco ("Superior Court"), to the extent the Superior Court participates in the City's Health Service System, under Section A8.428(e).

"Hired on or Before January 9, 2009" as used in this section means employees hired on or before January 9, 2009, by the City and County, the School District, the Community College District, or the Redevelopment Agency, excluding the following categories of employees: (1) as-needed employees who have never earned 1,040 or more hours of compensation during any 12-month period ending on or before January 9, 2009; (2) employees who have separated from employment with the Employers or

the Redevelopment Agency on or before January 9, 2009, and have less than 5 years of Credited Service with the Employers or the Redevelopment Agency; (3) former employees of the Redevelopment Agency who became employees of the City and County after February 28, 2015; (4) former employees of the Redevelopment Agency who left employment with the Redevelopment Agency and became employees of the City and County before February 1, 2012; and (5) former employees of the Redevelopment Agency who have received retiree health care coverage under the Public Employees Medical and Hospital Care Act (PEMCHA) on or before February 28, 2015.

"PERS" as used in this section shall mean the Public Employees' Retirement System of the State of California.

"Plan Year" as used in section A8.423 shall mean the twelve month period beginning on each July 1 and ending on June 30, or such other 12 month period as may be determined by the Health Service Board.

"Registered as Domestic Partners" as used in this section means persons who have established a domestic partnership according to the provisions of Chapter 62 of the San Francisco Administrative Code, or California state law, as amended from time to time, or the law of the city or county in which they reside or of the state outside of California in which they reside. Persons who live in a state, city, or county that does not recognize domestic partnership who submit a completed and notarized City and County Health Service System Declaration of Domestic Partnership Form to the Health Service System shall also be considered domestic partners under this section. Domestic partners who have formed their domestic partnership only by notarization of a declaration of Domestic Partnership as provided in Chapter 62 of the San Francisco Administrative Code shall not be recognized or treated as a domestic partnership under this Section unless and until the domestic partnership is registered or certified.

"Retirement System" as used in this section shall mean the San Francisco City and County Employees' Retirement System.

"Retired under the San Francisco City and County Employees' Retirement System" as used in this section includes persons who retire for service; retire for disability; or who receive a retirement or vesting allowance from the Retirement System.

A **"Retired Person"** as used in this section means:

(1) A former member of the health service system, Hired on or Before January 9, 2009, retired under the Retirement System and/or PERS (hereinafter, "Retired Employee who was Hired on or Before January 9, 2009");

(2) The surviving spouse or surviving domestic partner of an active employee of the Employers Hired on or Before January 9, 2009, provided that the surviving spouse or surviving domestic partner and the active employee have been married or Registered as Domestic Partners for a period of at least one year prior to the death of the active employee;

(3) The surviving spouse or surviving domestic partner of a Retired Employee who was Hired on or Before January 9, 2009, provided that the surviving spouse or surviving domestic partner and the Retired Employee who was Hired on or Before January 9, 2009 have been married or Registered as Domestic Partners for a period of at least one year prior to the death of the Retired Employee who was Hired on or Before January 9, 2009;

(4) A former member of the health service system, hired by the Employers on or after January 10, 2009, and retired under the Retirement System and/or PERS for disability, or retired under the Retirement System or PERS: (i) within 180 days of separation from employment from the Employers; and (ii) with 10 or more years of Credited Service with the Employers (hereinafter, "Retired Employee who was Hired on or After January 10, 2009");

(5) The surviving spouse or surviving domestic partner of an active employee of the Employers hired by the Employers on or after January 10, 2009, with 10 or more years of Credited Service with the Employers, who died in the line of duty where the surviving spouse or surviving domestic partner is entitled to a death allowance from the Retirement System as a result of the death in the line of duty, provided that the surviving spouse or surviving domestic partner and the active employee have been married or Registered as Domestic Partners for a period of at least one year prior to the death of the active employee; or

(6) The surviving spouse or surviving domestic partner of a Retired Employee who was Hired on or After January 10, 2009, provided that the surviving spouse or surviving domestic partner and the Retired Employee who was Hired on or After January 10, 2009, have been married or Registered as Domestic Partners for a period of at least one year prior to the death of the Retired Employee who was Hired on or After January 10, 2009.

B. Employer Contributions.

The City and County, the School District and the Community College District shall each contribute to the health service fund amounts sufficient for the following purposes, and subject to the following limitations:

(1) All funds necessary to efficiently administer the health service system.

(2) The City and County, the School, District and the Community College District shall contribute to the health service system fund with respect to each of their members an amount equal to the lesser of "the average contribution," as certified by the health service board in accordance with the provisions of Section A8.423, or the cost of the plan selected by the member.

C. Retired Employees Who Were Hired on or Before January 9, 2009.

For Retired Persons identified in A8.428 Subsections (a)(1), (a)(2) and (a)(3), the Employers shall contribute to the health service fund, amounts subject to the following limitations: Monthly contributions required from Retired Persons and the surviving spouses and surviving domestic partners of active employees and Retired Persons participating in the system shall be equal to the monthly contributions required from members in the system for health coverage excluding health coverage or subsidies for health coverage paid for active employees as a result of collective bargaining, with the following modifications:

(i) the total contributions required from Retired Persons who are also covered under Medicare shall be reduced by an amount equal to the amount contributed monthly by such persons to Medicare;

(ii) because the monthly cost of health coverage for Retired Persons may be higher than the monthly cost of health coverage for active employees, the City and County, the School District and the Community College District shall contribute funds sufficient to defray the difference in cost to the system in providing the same health coverage to Retired Persons and the surviving spouses and surviving domestic partners of active employees and Retired Persons as is provided for active employee members excluding health coverage or subsidies for health coverage paid for active employees as a result of collective bargaining;

(iii) after application of Subsections (3), (3)(i) and (3)(ii), the City and County, the School District and the Community College District shall contribute 50% of Retired Persons' remaining monthly contributions.

D. Retired Employees Who Were Hired on or After January 10, 2009 - Categories of Employees Eligible for 100% Employer Contribution.

For Retired Persons identified in A8.428 Subsections (a)(4), (a)(5) and (a)(6), the Employers shall contribute 100% of the employer contribution established in A8.428 Subsection (b)(3) for:

(i) A Retired Employee who was Hired on or After January 10, 2009, with 20 or more years of Credited Service with the Employers; and their surviving spouses or surviving domestic partners:

(ii) The surviving spouses or surviving domestic partners of active employees hired on or after January 10, 2009, with 20 or more years of Credited Service with the Employers;

(iii) Retired Persons who retired for disability; and their surviving spouses or surviving domestic partners; and

(iv) The surviving spouses or surviving domestic partners of active employees who died in the line of duty where the surviving spouse or surviving domestic partner is entitled to a death allowance as a result of the death in the line of duty.

E. Retired Employees Who Were Hired on or After January 10, 2009 - Categories of Employees Eligible for 50%-75% Employer Contribution.

For Retired Persons identified in A8.428 Subsections (a)(4), (a)(5) and (a)(6), the Employers shall contribute:

(i) 50% percent of the employer contribution established in A8.428 Subsection (b)(3) for a Retired Employee who was Hired on or After January 10, 2009, with, at least 10 but less than 15 years of Credited Service with the Employers: their surviving spouses or surviving domestic partners: and the surviving spouses or surviving domestic partners of active employees hired on or after January 10, 2009, with at least 10 but less than 15 years of Credited Service with the Employers; and

- (ii) 75% percent of the employer contribution established in A8.428

Subsection (b)(3) for a Retired Employee who was Hired on or After January 10, 2009, with at least 15 but less than 20 years of Credited Service with the Employers; their surviving spouses or surviving domestic partners; and the surviving spouses or surviving domestic partners of active employees hired, on or after January 10, 2009, with at least 15 but less than 20 years of Credited Service with the Employers.

F. Retired Employees Who Were Hired on or After January 10, 2009 - Categories of Employees Eligible for Access to Retiree Medical Benefits Coverage.

An employee hired on or after January 10, 2009, and retired under the Retirement System or PERS with five (5) or more years Credited Service with the Employers, shall be eligible to receive health benefits as a member of the health service system, provided that he or she makes monthly contributions equal to one hundred percent, (100%) of the total premiums for health coverage as established by the Health, Service Board, including the total cost for dependent coverage. At such time as he or she becomes eligible to receive benefits under A8.428 Subsection (a)(4), the Employers shall contribute the amounts established in A8.428 Subsections (b)(4), (b)(5), and (c), as applicable.

G. Chart Summarizing Employer Contributions Under A8.428 Subsections (b)(4), (b)(5) and (b)(6) For Employees Hired on or After January 10, 2009.

<u>Years of Credited Service At Retirement</u>	<u>Percentage of Employer Contribution Established in A8.428 Subsection (b)(3)</u>
1. <u>Less than 5 years of Credited Service with the Employers (except for the surviving spouses or surviving domestic partners of active employees who died in the line of duty)</u>	<u>No Retiree Medical Benefits Coverage</u>
2. <u>At least 5 but less than 10 years of Credited Service with the Employers; or greater than 10 years of Credited Service with the Employers but not eligible to receive benefits under Subsections (a)(4), (b)(4) and (b)(5)</u>	<u>0% Access to Retiree Medical Benefits Coverage, Including Access to Dependent Coverage, But No Employer Contribution; Employee Pays Health Insurance Premium</u>

<u>(A8.428 Subsection (b)(6))</u>	
3. <u>At least 10 but less than 15 years of Credited Service with the Employers</u> <u>(A8.428 Subsection (b)(5))</u>	<u>50%</u>
4. <u>At least 15 but less than 20 years of Credited Service with the Employers</u> <u>(A8.428 Subsection (b)(5))</u>	<u>75%</u>
5. <u>At least 20 years of Credited Service with the Employers; Retired Persons who retired for disability; surviving spouses or surviving domestic partners of active employees who died in the line of duty</u> <u>(A8.428 Subsection (b)(4))</u>	<u>100%</u>

The above chart is a simplified summary of Employer contributions under A8.428 Subsections (b)(4), (b)(5) and (b)(6) for employees hired on or after January 10, 2009. The express language of Subsections (b)(4), (b)(5) and (b)(6), and not the summary chart or its content, shall determine Employer contributions.

H. Employees Who Separated From Employment on or Before June 30, 2001, and Who Retired on or After January 7, 2012.

Notwithstanding any other provisions of A8.428 for Retired Persons who separated from employment on or before June 30, 2001, and who retired on or after January 7, 2012, the monthly contributions required from such Retired Persons, and the surviving spouses and surviving domestic partners of active employees and such Retired Persons participating in the system, shall be equal to the monthly contributions required from members in the system for health coverage, excluding health coverage or subsidies for health coverage paid for employees as a result of collective bargaining, with the following modifications:

- (i) the total contributions required from Retired Persons who are also covered under Medicare shall be reduced by an amount equal to the amount contributed monthly by such persons to Medicare; and

(ii) because the monthly cost of health coverage for Retired Persons may be higher than the monthly cost of health coverage for active employees, the City and County, the School District and the Community College District shall contribute funds sufficient to defray the difference in cost to the system in providing the same health coverage to Retired Persons and the surviving spouses and surviving domestic partners of active employees and Retired Persons as is provided for active employee members excluding health coverage or subsidies for health coverage paid for active employees as a result of collective bargaining.

(a) The City and County, the San Francisco Unified School District and the San Francisco Community College District shall contribute to the health service system fund 50% of the monthly contributions required for the first dependent of Retired Persons in the system. Except as hereinbefore set forth, the City and County, the School District and the Community College District shall not contribute to the health service system fund any sums on account of participation in the benefits of the system by members' dependents, except surviving spouses and surviving domestic partners, Retired Persons' dependents, except surviving spouses and surviving domestic partners, persons who retired and elected not to receive benefits from the Retirement System; resigned employees and teachers defined in Section A8.425, and any employee whose compensation is fixed in accordance with Sections A8.401, A8.403, or A8.404 of this Charter and whose compensation therein includes an additional amount for health and welfare benefits or whose health service costs are reimbursed through any fund established for said purpose by ordinance of the Board of Supervisors. Notwithstanding any other provision of Charter Section A8.428, the City and County, the San Francisco Unified School District and the San Francisco Community College District shall not contribute to the health service system fund any contributions for the

first dependent of a Retired Person who separated from employment on or before June 30, 2001, and who retired on or after January 7, 2012.

(b) It shall be the duty of the Board of Supervisors, the Board of Education and the Governing Board of the Community College District annually to appropriate to the health service system fund such amounts as are necessary to cover the respective obligations of the City and County, the School District and the Community College District hereby imposed. Contributions to the health service system fund of the City and County, of the School District and of the Community College District shall be charged against the general fund or the school, utility, bond or other special fund concerned.

(c) To the extent the Superior Court elects to participate in the City's Health Service System for the provision of active and retiree health care benefits, Superior Court employees shall be treated the same as City employees for the purposes of vesting, employer contribution rates, and benefit levels, in accordance with the Trial Court Employment Protection and Governance Act and applicable State law. The Superior Court shall pay all administrative and health care costs related to the Superior Court's covered employees or retirees as a participating Employer. The Superior Court may withdraw from participation in the City's Health Service System at any time, which shall not require an amendment to this Charter.

(d) Notwithstanding the retiree health care eligibility requirements set forth above, a former employee of the Redevelopment Agency Hired on or Before January 9, 2009 must have been employed by the City and County after January 9, 2009 to be eligible for retiree health care coverage under this section. In adopting the Charter amendment revising Sections A8.428 and A8.432 on November 4, 2014 the voters do not intend that it affect the rights of former employees of the Redevelopment

Agency Hired on or Before January 9, 2009, who were already eligible for retiree health care coverage as of November 4, 2014.

(e) The purpose of the January 10, 2009, Charter amendment is to amend Section A8.428 to change the required years of service and employer retiree health care contribution amounts for employees hired on or after January 10, 2009. Nothing in that Charter amendment shall expand or contract the groups of employees eligible for retiree health care benefits beyond those groups eligible as of June 3, 2008.

(Amended November 1984; November 2000; November 2004; Proposition B, Approved 6/3/2008; Proposition C, Approved 11/8/2011; Proposition D, Approved 11/4/2014)

XVII. CHARTER SECTION A8.429 – CONTRIBUTIONS TO FUND

The health service board shall determine and certify to the controller the amount to be paid monthly by the members of the system to the health service system fund for the purposes of the system hereby created. The controller shall deduct said sums from the compensation of the members and shall deposit the same with the treasurer of the City and County to the credit of the health service system fund.

Such deductions shall not be deemed to be a reduction of compensation under any provision of this Charter.

The health service board shall have control of the administration and investment of the health service system fund, provided that all investments shall be of the character legal for insurance companies in California. Disbursements from the fund shall be made only upon audit by the controller and the controller shall have and exercise the accounting and auditing powers over the health service system fund which are vested in him by this Charter with respect to all other municipal boards, officers and commissions.

XVIII. CHARTER SECTION A8.430 – "MEDICAL CARE" DEFINED

The term "medical care" shall be defined by the health service board. All acts performed and services rendered under the provisions of this section shall be performed

in accordance with the provisions as to professional conduct prescribed by the statutes of the State of California regulating such professional conduct and services.

XIX. CHARTER SECTION A8.431 – LIMITATION OF CLAIMS BY MEMBERS

Except as herein provided, members of the system shall have and possess no claim or recourse against any of the funds of the municipality by virtue of the adoption or operation of any plan for rendering medical care, indemnifying costs of said care or carrying insurance against such costs, but except as herein provided, the claim and recourse of any such member shall be limited solely to the funds of the system. All expenses of the system shall be paid exclusively from the health service system fund, and, except as herein provided, the City and County and the San Francisco Unified School District shall not appropriate or contribute funds in any manner for the purposes of the system hereby established and provided.

XX. CHARTER SECTION A8.431-1 – SEVERABILITY

Any Section or part of any Section in this Charter, insofar as it should conflict with the provisions of Charter Sections 12.200 through 12.203 or A8.420 through A8.431, or with any part thereof, shall be superseded by the contents of Charter Sections 12.200 through 12.203 or A8.420 through A8.431. Charter Sections 12.200 through 12.203 or A8.420 through A8.431 shall be interpreted to be consistent with all federal and state laws, rules and regulations. If any of the words, phrases, clauses, sentences, subsections, or provisions of Charter Sections 12.200 through 12.203 or A8.420 through A8.431 are held to be invalid or unconstitutional by a final judgment of a court, such decision shall not affect the validity of the remaining words, phrases, clauses, sentences, subsections, or provisions of Charter Sections 12.200 through 12.203 or A8.420 through A8.431. If any words, phrases, clauses, sentences, subsections, or provisions of Charter Sections 12.200 through 12.203 or A8.420 through A8.431 are

held invalid as applied to any person, circumstance, employee or category of employee, such invalidity shall not affect any application of Charter Sections 12.200 through 12.203 or A8.420 through A8.431 which can be given effect. Charter Sections 12.200 through 12.203 or A8.420 through A8.431 shall be broadly construed to achieve their stated purpose.

(Added by Proposition C, Approved 11/8/2011)

ADMINISTRATIVE CODE SECTIONS

XXI. ADMINISTRATIVE CODE SECTION 16.550. – PURPOSE.

(a) The Charter of the City and County of San Francisco provides that the trustees of the Retirement Board, who are entrusted with the administration of the San Francisco City and County Employee's Retirement System, shall include three trustees elected from the active and retired members of the Retirement System. As used in this Article, a retired member of the Retirement System shall mean a person who is in receipt of a retirement allowance relating to his or her membership in the retirement system.

(b) The Charter of the City and County of San Francisco provides that the trustees of the Health Service Board, who are entrusted with the administration of the San Francisco City and County Employees' Health Service System, shall include four trustees elected from the active and retired members of the Health Service System. For the purposes of a Health Service System election, a retired member of the Health Service System shall mean a person who is a member of the Health Service System retired under the San Francisco City and County Employees' Retirement System, State Teachers Retirement System (STRS), Public Employees Retirement System (PERS), and the surviving spouse of an active employee and the surviving spouse of a retired

employee, provided that the surviving spouse and the active or retired employee have been married for a period of at least one year prior to the death of the active or retired employee.

(c) The Charter of the City and County of San Francisco provides that the trustees of the Retiree Health Care Trust Fund, who are entrusted with providing a funding source to defray the cost of the City's and Participating Employers' obligations to pay for health coverage for retired persons and their survivors entitled to health care coverage under Charter Section A8.428, shall include two trustees elected from active employees and retired members of the City's Health Service System. One of the elected trustees shall be an active City or Participating Employer employee member and one shall be a retired City or Participating Employer member as of the date of their respective elections. For the purposes of a Retiree Health Care Trust Fund election, a retired member of the Health Service System shall mean a person who retired from City employment, or from a Participating Employer, and who is a member of the Health Service System retired under the San Francisco City and County Employees' Retirement System, the State Teachers Retirement System (STRS), or the Public Employees Retirement System (PERS), and the surviving spouse or domestic partner of an active employee and the surviving spouse or domestic partner of a retired employee, provided that the surviving spouse or domestic partner and the active or retired employee have been married for a period of at least one year prior to the death of the active or retired employee. For the purposes of a Retiree Health Care Trust Fund election, an active member of the Health Service System shall mean an active City employee or an active employee of a Participating Employer. As used in this section, Participating Employer means the San Francisco Unified School District and the San Francisco Community College District, following a resolution by these employers' respective governing boards to participate in the Retiree Health Care Trust Fund.

(d) The failure to abide by election procedure obligations and deadlines in San Francisco Administrative Code Sections 16.550-16.565 shall not invalidate an election if the election has been conducted fairly and in substantial compliance with and conformity to the legal requirements.

(e) Whenever the term of office of such an elected trustee expires or whenever a vacancy occurs in such an office so that an election is necessary to fill a present or expected vacancy, the following provisions shall govern the election procedure.

(Added by Ord. 512-80, App. 10/29/80; amended by Ord. 287-94, App. 8/4/94; Ord. 378-95, App. 12/7/95; Ord. 285-08, File No. 081190, App. 12/5/2008)

XXII. ADMINISTRATIVE CODE SECTION 16.551. – RETIREMENT BOARD, HEALTH SERVICE BOARD OR RETIREE HEALTH TRUST FUND BOARD TO ORDER ELECTIONS.

If a vacancy occurs, or will occur, in the office of an elected trustee prior to the date that the term of that office expires, the Retirement Board, Health Service Board or Retiree Health Trust Fund Board shall order a special election to fill the vacancy for the unexpired portion of the term of office, unless another election to a Retirement Board, Health Service Board or Retiree Health Trust Fund Board office is scheduled to be completed within six months after the vacancy has, or shall, occur, in which case the elections shall be combined; provided, however, that a separate special election shall be required if the election which has already been scheduled will occur too soon to nominate and select candidates for the more recent vacancy. Whenever the Retirement Board, Health Service Board or Retiree Health Trust Fund Board orders an election, the respective Board shall specify whether the election is to be conducted by the Department of Elections or by an unbiased independent contractor ("Contractor"). Special elections may be held on an expedited basis as determined by the Department

of Elections. The first Retiree Health Trust Fund Board election shall be a special election conducted by the Department of Elections.

(Added by Ord. 512-80, App. 10/29/80; amended by Ord. 287-94, App. 8/4/94; Ord. 378-95, App. 12/7/95; Ord. 285-08, File No. 081190, App. 12/5/2008)

XXIII. ADMINISTRATIVE CODE SECTION 16.552. – DATES OF ELECTION.

Whenever an election is necessary, either at the completion of a term of office or to fill an unexpired term of office, the Retirement Board, Health Service Board or Retiree Health Trust Fund Board shall specify the dates during which ballots may be marked and delivered. However, the dates designated by the Retirement Board, Health Service Board or Retiree Health Trust Fund Board shall not be within one month before or after an election which has been otherwise scheduled and which involves residents of the City and County of San Francisco as electors, unless the Department of Elections agrees to the dates.

(Added by Ord. 512-80, App. 10/29/80; amended by Ord. 378-95, App. 12/7/95; Ord. 285-08, File No. 081190, App. 12/5/2008)

XXIV. ADMINISTRATIVE CODE SECTION 16.553. – NOTICE TO MEMBERS AND RETIRED MEMBERS; NOMINATION OF MEMBERS AND RETIRED MEMBERS.

The Retirement Board, Health Service Board or Retiree Health Trust Fund Board shall thereafter notify the members and retired members of the Retirement System or Health Service System respectively of the following:

- (a) The necessity for an election;
- (b) The procedure for nomination and selection of candidates to serve on the Board; and
- (c) The dates that ballots may be marked and delivered and the procedure for voting.

The period of time during which nominations may be made shall be set by the Retirement Board, Health Service Board or Retiree Health Trust Fund Board, but in no

event shall be less than 31 days. Any person nominated to serve as a trustee of the Retirement Board, Health Service Board or Retiree Health Trust Fund Board shall, on forms provided by the respective Board for this purpose and by the date set by the respective Board, verify acceptance of the nomination and agree to serve if elected before he or she may be listed as a candidate.

In any election for membership on the Health Service Board or Retiree Health Trust Fund Board, when only one candidate has filed nomination papers, the Department of Elections or Contractor shall not conduct an election and shall declare the sole candidate to be a member of the Health Service Board or Retiree Health Trust Fund Board.

(Added by Ord. 512-80, App. 10/29/80; amended by Ord. 287-94, App. 8/4/94; Ord. 378-95, App. 12/7/95; Ord. 285-08, File No. 081190, App. 12/5/2008)

XXV. ADMINISTRATIVE CODE SECTION 16.553-1. – CANDIDATE QUALIFICATION STATEMENTS.

(a) Content and Form of Statement. Candidates may file a candidate qualification statement including the name, age and occupation of the candidate and a description of no more than 200 words of the candidate's education and qualifications as expressed by the candidate. To ensure that all statements are filed in a uniform format, the statement shall be in a manner specified, and on a form provided, by the Department of Elections, or Contractor, for this purpose.

(b) Deadline for Submission of Statement. Candidates who choose to submit a candidate qualification statement shall file the statement with the Department of Elections, or Contractor, at the date and time established by that department.

(c) Inclusion of Nominators and Supporters. The candidate qualification statement may, but need not, include the names of some or all of the candidate's nominators. The statement may also include the names of individuals and entities which support the candidate but did not serve as nominators. The names of such supporters

shall not be published as part of the candidate's qualification statement unless the candidate provides the supporter's written authorization at the time the statement is submitted to the Director of Elections or Contractor. The authorization shall be in a form prescribed by the Director of Elections or Contractor. If the candidate chooses to include the names of nominators, or other supporters in the candidate qualification statement, these names shall be counted toward the 200-word limit.

(d) Limitations. The candidate qualification statement shall not include the party affiliation of the candidate, nor membership or activity in partisan political organizations.

(e) Withdrawal of Statement. A candidate may withdraw, but not change, his or her candidate qualification statement by filing with the Director of Elections, or Contractor, a signed and sworn statement of withdrawal no later than 5:00 p.m. of the thirtieth day prior to the election.

(Added by Ord. 285-08, File No. 081190, App. 12/5/2008)

XXVI. ADMINISTRATIVE CODE SECTION 16.553-2. – CANDIDATE DISCLOSURE REQUIREMENTS.

Each candidate for Retirement Board, Health Service Board or Retiree Health Trust Fund Board elections shall file, by the date set by the respective Board for verifying acceptance of the nomination, a statement disclosing the information required by the disclosure category for the elective office sought by the candidate established in the Conflict of Interest Code. Candidates shall file such statements with the respective Board on the same forms as used by filers under Section 3.1-100 et seq. of the Conflict of Interest Code. This statement shall not be required if the candidate has filed, within 90 days prior to accepting the nomination, a statement at disclosure category one (1) with the City and County of San Francisco.

(Added by Ord. 285-08, File No. 081190, App. 12/5/2008)

XXVII. ADMINISTRATIVE CODE SECTION 16.554. – NOTICE TO DEPARTMENT OF ELECTIONS OR CONTRACTOR.

The Retirement Board, Health Service Board or Retiree Health Trust Fund Board shall notify the Department of Elections or Contractor at least 120 days prior to the first day that ballots may be marked and delivered (hereafter referred to as the "First Voting Day") that an election shall be held.

(Added by Ord. 512-80, App. 10/29/80; amended by Ord. 378-95, App. 12/7/95; Ord. 285-08, File No. 081190, App. 12/5/2008)

XXVIII. ADMINISTRATIVE CODE SECTION 16.555. – NOTICE TO DEPARTMENTS; APPOINTMENT OF ELECTION OFFICERS.

The Department of Elections or Contractor shall notify each department, office and agency of the City and County of San Francisco (hereunder referred to as "department") at least 90 days prior to the First Voting Day that the department must designate an employee who shall serve as Election Officer for that department and must inform the Department of Elections or Contractor at least 60 days prior to the First Voting Day of the identity of such officer. The Department of Elections or Contractor shall supply each department with a form which can be returned to the Department of Elections or Contractor which identifies the employee who has been designated Election Officer. If any department has not designated an Election Officer by the appointed deadline, the Department of Elections or Contractor shall treat the department head as the Election Officer until such designation has been made.

(Added by Ord. 512-80, App. 10/29/80; amended by Ord. 287-94, App. 8/4/94; Ord. 378-95, App. 12/7/95; Ord. 285-08, File No. 081190, App. 12/5/2008)

XXIX. ADMINISTRATIVE CODE SECTION 16.556. – INSTRUCTIONS TO ELECTION OFFICERS.

The Department of Elections or Contractor shall provide written instructions to each Election Officer at least 21 days prior to the First Voting Day, informing such officer of dates on which ballots will be distributed and collected and the procedure to be

followed for their distribution and collection. If any department has failed to designate an Election Officer by the time that the Department of Elections or Contractor sends these written instructions, the Department of Elections or Contractor shall thereafter treat the administrative head of the department as the Election Officer until another employee has been designated as such by that department.

(Added by Ord. 512-80, App. 10/29/80; amended by Ord. 378-95, App. 12/7/95; Ord. 285-08, File No. 081190, App. 12/5/2008)

XXX. ADMINISTRATIVE CODE SECTION 16.557. – DELIVERY OF BALLOTS AND NAMES OF ELIGIBLE VOTERS TO DEPARTMENT OF ELECTIONS OR CONTRACTOR.

The Retirement Board, Health Service Board or Retiree Health Trust Fund Board shall furnish the Department of Elections or Contractor with the names of the eligible nominees at least 35 days prior to the First Voting Day.

The Retirement Board, Health Service Board or Retiree Health Trust Fund Board shall also furnish the Department of Elections or Contractor with a list of the members and retired members of the Retirement System or Health Service System respectively eligible to vote ("voters") in the election at the same time that it furnishes the names of the eligible nominees. A supplemental list shall be furnished to the Department of Elections or Contractor within two days of the First Voting Day, which list shall provide the names of eligible voters not included on the original list. These lists shall be in the format required by the Department of Elections or Contractor. These lists shall include the last known addresses for the members and retired members. For the active members, at the election of the entity conducting the election the department address shall be provided as an alternative.

Upon request, the City's Health Service System shall provide all information to Contractor, or the Department of Elections, necessary to conduct the Retiree Health Trust Fund Board nomination and election process including, but not limited to,

information regarding voter lists, voter contact information and Health Service System membership status.

(Added by Ord. 512-80, App. 10/29/80; amended by Ord. 287-94, App. 8/4/94; Ord. 378-95, App. 12/7/95; Ord. 285-08, File No. 081190, App. 12/5/2008)

XXXI. ADMINISTRATIVE CODE SECTION 16.558. – BALLOTS TO CONTAIN INSTRUCTIONS FOR VOTING.

Each ballot shall contain instructions printed on it informing the voters of the procedure to be used in marking the ballot. Each ballot, or ballot return envelope, shall inform the voter that there are three ways to return the ballot:

(a) By placing the ballot in the signed and sealed return envelope provided by the Contractor or the Department of Elections in the container maintained for such purpose by the Election Officer of the voter's department, or by otherwise using the collection procedure arranged for by the Election Officer;

(b) By delivering the signed and sealed return envelope provided by the Contractor or the Department of Elections with the ballot enclosed personally to the Department of Elections or the Contractor; and

(c) By placing a stamp on the ballot return envelope and mailing the ballot and envelope to the Department of Elections or the Contractor.

The instructions shall also note the date by which ballots must be delivered to be counted.

(Added by Ord. 512-80, App. 10/29/80; amended by Ord. 287-94, App. 8/4/94; Ord. 378-95, App. 12/7/95; Ord. 285-08, File No. 081190, App. 12/5/2008)

XXXII. ADMINISTRATIVE CODE SECTION 16.559. – BALLOTS TO BE PLACED IN ADDRESSED ENVELOPES; EXTRA BALLOTS.

(a) Members. Each ballot and ballot return envelope shall be mailed in a separate envelope addressed to each employee eligible to vote at the member's individual address provided by the Retirement System, Health Service System or

Retiree Health Trust Fund Board. In the alternative, at the election of the entity conducting the election, ballots shall be delivered in care of his or her department.

(b) Retired Members. Each ballot and ballot return envelope shall be mailed in a separate envelope addressed to the retired member at the address provided by the Retirement System, Health Service System or Retiree Health Trust Fund Board.

(c) Additional ballots shall be printed and available for members and retired members of the Retirement System or Health Service System who are eligible to vote but did not receive an individually addressed ballot.

(Added by Ord. 512-80, App. 10/29/80; amended by Ord. 287-94, App. 8/4/94; Ord. 378-95, App. 12/7/95; Ord. 285-08, File No. 081190, App. 12/5/2008)

XXXIII.

ADMINISTRATIVE CODE SECTION 16.560. – DELIVERY OF BALLOTS AND INSTRUCTIONS TO ELECTION OFFICERS.

(a) Members. The Department of Elections or Contractor shall cause the ballots and accompanying envelopes to be mailed or delivered pursuant to Section 16.559(a) not later than 10 days prior to the First Voting Day, along with written instructions for their proper distribution and collection and any other pertinent guidelines as set out in these provisions or as otherwise applicable.

(b) Retired Members. The Department of Elections or Contractor shall deposit in the mail the ballots and accompanying envelopes to each retired member at least 10 business days prior to the First Voting Day.

(Added by Ord. 512-80, App. 10/29/80; amended by Ord. 287-94, App. 8/4/94; Ord. 378-95, App. 12/7/95; Ord. 285-08, File No. 081190, App. 12/5/2008)

XXXIV.

ADMINISTRATIVE CODE SECTION 16.561. – DUTIES OF ELECTION OFFICERS.

Each Election Officer shall:

(a) Prior to the date that ballots are delivered, inform the department or employee responsible for distributing paychecks to employees of the department of the

dates during which ballots are to be distributed to employees and of the responsibility of the Payroll Department to make arrangements to distribute a ballot with each paycheck by a date that will allow each voter at least three days to mark and deliver the ballot;

(b) Upon receipt of the ballots, coordinate his or her efforts and those of the Payroll Department to insure that the ballots are ready to be distributed along with paychecks by a date that will allow each voter at least three days to mark and deliver the ballot;

(c) Provide notice to employees who are in the Retirement System or Health Service System but would not be likely to receive ballots along with their paychecks, such as employees on the temporary payroll, that ballots are available;

(d) Provide ballots to employees who did not, or would not, receive them along with their paychecks pursuant to the procedure established by the Department of Elections or Contractor;

(e) Establish and maintain a collection procedure so that employees have a convenient method of returning ballots, which method shall, where possible, make use of at least one container in which ballots can be placed; and

(f) Return the ballots which have been received or otherwise collected according to the collection procedure established by such officer to the Department of Elections or Contractor, either personally or by the inter-office mail system, in a timely manner so that the ballots will be delivered to the Department of Elections or Contractor by the date established by the Retirement Board, the Health Service Board or Retiree Health Trust Fund Board as the final date for such delivery.

(Added by Ord. 512-80, App. 10/29/80; amended by Ord. 287-94, App. 8/4/94; Ord. 378-95, App. 12/7/95; Ord. 285-08, File No. 081190, App. 12/5/2008)

XXXV. ADMINISTRATIVE CODE SECTION 16.562. – DUTY OF PAYROLL DEPARTMENT.

The Payroll Department shall provide cooperation and assistance in sorting the ballots or performing other tasks necessary to insure that the ballots are distributed along with paychecks by a date that will allow each voter at least three days to mark and deliver the ballot.

(Added by Ord. 512-80, App. 10/29/80; amended by Ord. 378-95, App. 12/7/95; Ord. 285-08, File No. 081190, App. 12/5/2008)

XXXVI.

ADMINISTRATIVE CODE SECTION 16.563. – COUNTING OF BALLOTS AND CERTIFICATION OF NEW TRUSTEE.

(a) The Department of Elections or Contractor shall thereafter count the ballots in such a manner that the identity of the individual casting any particular ballot will not be disclosed. Each ballot shall be counted so long as it has been properly marked, signed and delivered. The Department of Elections or Contractor shall certify the new Health Service Board or Retiree Health Trust Fund Board trustee.

(b) Within five days of the close of voting and prior to certification, the Retiree Health Trust Fund Board secretary shall attest to the Department of Elections or contractor that there is one retired member trustee and one active member trustee candidate to fill the two elected Retiree Health Trust Fund Board trustee positions. For purposes of Retiree Health Trust Fund Board elections, the date of the election shall be the day the election is certified by the Department of Elections or Contractor. In the event that the active member candidate with the highest number of votes is no longer an active member on the day the election is certified, the Department of Elections shall certify the active member candidate with the next highest number of votes. In the event that the retired member candidate with the highest number of votes is no longer a retired member on the day the election is certified, the Department of Elections shall certify the retired member candidate with the next highest number of votes.

(c) Within five days of the close of voting and prior to certification, the Executive Director of the Retirement System shall attest to the Department of Elections or Contractor whether there is a retired member serving as trustee on the Retirement Board:

(i) If, at that time, there is no retired member serving as trustee, the Department of Elections or Contractor shall certify the individual receiving the highest number of votes as the newly elected trustee of the Retirement Board.

(ii) If, at that time, there is a retired member serving as trustee, the Department of Elections or Contractor shall certify the member (not a retired member) receiving the highest number of votes as the newly elected trustee of the Retirement Board.

Where there is no vacancy, the Department of Elections or Contractor shall certify the new Retirement Board trustee as close to the expiration of the term as reasonably possible.

(Added by Ord. 512-80, App. 10/29/80; amended by Ord. 287-94, App. 8/4/94; Ord. 378-95, App. 12/7/95; Ord. 285-08, File No. 081190, App. 12/5/2008)

XXXVII.

ADMINISTRATIVE CODE SECTION 16.564. – RETIREMENT BOARD, HEALTH SERVICE BOARD OR RETIREE HEALTH TRUST FUND BOARD TO REIMBURSE DEPARTMENT OF ELECTIONS.

The Retirement Board, Health Service Board or Retiree Health Trust Fund Board shall reimburse the Department of Elections for the actual expenses incurred by it in conducting Retirement Board, Health Service Board or Retiree Health Trust Fund Board elections respectively. The Retirement Board, Health Service Board or Retiree Health Trust Fund Board shall pay all Contractor expenses when the respective Board specifies that a Contractor conduct a Retirement Board, Health Service Board or Retiree Health Trust Fund Board election.

(Added by Ord. 512-80, App. 10/29/80; amended by Ord. 378-95, App. 12/7/95; Ord. 285-08, File No. 081190, App. 12/5/2008)

XXXVIII.

ADMINISTRATIVE CODE SECTION 16.565. – GIVING, RECEIVING ANYTHING OF VALUE IN CONSIDERATION OF VOTING PROHIBITED.

(a) No person shall directly or through any other person pay, lend, or contribute or offer or promise to pay, lend, or contribute, any money or other valuable consideration to or for any voter or to or for any other person to:

(1) Induce any person to:

(A) Vote at any Retirement Board, Health Service Board or Retiree Health Trust Fund Board election;

(B) Refrain from voting at any Retirement Board, Health Service Board or Retiree Health Trust Fund Board election;

(C) Vote or refrain from voting at a Retirement Board, Health Service Board or Retiree Health Trust Fund Board election for or against any particular person or measure; or

(2) Reward any person for having:

(A) Voted at any Retirement Board, Health Service Board or Retiree Health Trust Fund Board election;

(B) Refrained from voting at any Retirement Board, Health Service Board or Retiree Health Trust Fund Board election; or

(C) Voted or refrained from voting at a Retirement Board, Health Service Board or Retiree Health Trust Fund Board election for or against any particular person or measure.

(b) No person may directly or through any other person solicit, accept, receive, agree to accept, or contract for, before, during or after a Retirement Board, Health Service Board or Retiree Health Trust Fund Board election, any money, gift,

loan, or other valuable consideration, offer, place, or employment for himself or herself or any other person because he or she or any other person:

(1) Voted or agreed to vote at any Retirement Board, Health Service Board or Retiree Health Trust Fund Board election;

(2) Refrained or agreed to refrain from voting at a Retirement Board, Health Service Board or Retiree Health Trust Fund Board election;

(3) Voted, agreed to vote, refrained from voting, or agreed to refrain from voting for or against any particular person or measure at a Retirement Board, Health Service Board or Retiree Health Trust Fund Board election; or

(4) Induced any other person to:

(A) Vote or agree to vote at any Retirement Board, Health Service Board or Retiree Health Trust Fund Board election;

(B) Refrain from voting or agree to refrain from voting at a Retirement Board, Health Service Board or Retiree Health Trust Fund Board election; or

(C) Vote, agree to vote, refrain from voting, or agree to refrain from voting for or against any particular person or measure at a Retirement Board, Health Service Board or Retiree Health Trust Fund Board election.

(c) Any person violating any of the provisions of this section shall be guilty of a misdemeanor and, upon a final judgment of conviction of same, shall be removed from office and may also be subject to a penalty of not more than six months in jail and/or fine of not more than \$1,000, as well as removal.

(d) "Person" means an individual, partnership, corporation, association, firm or other organization or entity, however organized.

(e) Nothing in this section shall prohibit the following:

(1) Making an expenditure for, offering, providing, accepting or receiving transportation to or from the polls; or

(2) Making an expenditure for, organizing or attending a gathering providing complementary food, beverages and/or entertainment, provided that no valuable consideration is offered, promised, solicited, accepted or received in consideration of the conduct described in subsection (a); or

(3) Making expenditures for the organization and conduct of get-out-the-vote rallies.

(f) Pursuant to the procedures set forth in San Francisco Charter Sections 15.102 and C3.699-10 et seq., the Ethics Commission shall adopt regulations consistent with this Section for the purpose of implementing this Section while avoiding any application that would prohibit conduct protected by the United States Constitution or the California Constitution.

(Added by Ord. 285-08, File No. 081190, App. 12/5/2008)

XXXIX.

ADMINISTRATIVE CODE SECTION 16.700. – PARTICIPATION.

The following shall be eligible to participate in the Health Service System:

A. City and County Employees.

(1) All permanent employees of the City and County of San Francisco whose normal work week at the time of inclusion is the system in not less than twenty (20) hours;

(2) All regularly scheduled provisional employees of the City and County of San Francisco whose normal work week at the time of inclusion in the system is not less than twenty (20) hours;

(3) All other employees of the City and County of San Francisco, including "as needed" employees, who have worked one thousand and forty hours (1040) in any consecutive twelve (12) month period and whose normal work week at the time of inclusion in the system is not less than twenty (20) hours.

B. Elected Officials.

C. All Members of The Following Boards And Commissions During Their Time In Service To The City And County Of San Francisco:

- (1) Access Appeals Commission
- (2) Airport Commission
- (3) Art Commission
- (4) Asian Art Commission
- (5) Board of Education
- (6) Board of Appeals
- (7) Building Inspection Commission
- (8) Civil Service Commission
- (9) Commission on the Aging
- (10) Commission on the Environment
- (11) Commission on the Status of Women
- (12) Community College District Governing Board
- (13) Concourse Authority
- (14) Elections Commission
- (15) Entertainment Commission
- (16) Ethics Commission
- (17) Fine Arts Museums Board of Trustees
- (18) Fire Commission
- (19) Film and Video Arts Commission
- (20) First Five Commission
- (21) Health Commission
- (22) Health Service Board
- (23) Human Rights Commission
- (24) Human Services Commission

- (25) Juvenile Probation Commission
- (26) Law Library Board of Trustees
- (27) Library Commission
- (28) Municipal Transportation Authority
- (29) Planning Commission
- (30) Police Commission
- (31) Port Commission
- (32) Public Utilities Commission
- (33) Recreation and Parks Commission
- (34) Residential Rent Stabilization and Arbitration Board
- (35) Retiree Health Care Trust Fund Board
- (36) Retirement Board
- (37) Small Business Commission
- (38) Sunshine Ordinance Task Force
- (39) War Memorial and Performing Arts Center Board
- (40) Youth Commission

- D. All Officers and Employees as Determined Eligible by The Board of Education of the San Francisco Unified School District.**
- E. All Officers and Employees as Determined Eligible by The Governing Board of the San Francisco Community College District.**
- F. All Officers and Employees as Determined Eligible by The Governing Bodies of the San Francisco Transportation Authority, San Francisco Parking Authority, San Francisco Redevelopment Agency, Treasure Island Development Authority, San Francisco Superior Court and Any Other Employees as Determined Eligible by Ordinance.**
- G. All Retirees, Surviving Spouses, Surviving Domestic Partners and Resigned Employees. For The Purposes of This Chapter, Resigned Employees Shall Have the Same Meaning as Used in Section A8.425 Of The Charter.**
- H. All Dependents of the Foregoing Categories as They Are Determined Eligible By The Appropriate Governing Body.**

(Amended by Ord. 67-86, App. 3/7/86; Ord. 289-00, File No. 001549, App. 12/22/2000; Ord. 181-04, File No. 040741, App. 7/22/2004; Ord. 46-15, File No. 131122, App. 4/17/2015, Eff. 5/17/2015)

XL. ADMINISTRATIVE CODE SECTION 16.701. – ELIGIBILITY FOR EMPLOYER CONTRIBUTIONS.

The following shall be eligible to receive contributions for participation in the Health Service System as set forth below:

(a) Members of boards and commissions referenced above in Section 16.700(c) and retirees, surviving spouse and domestic partners referenced above in Section 16.700(g), shall receive only the Charter-determined contribution. Members of boards and commissions who were in service on the effective date of this ordinance shall maintain the same types of benefits during their term of service.

(i) Except as may otherwise be required under state or federal law, the surviving spouse or surviving domestic partner of an active employee who is killed in the performance of his or her duty shall continue to receive health benefits under the same terms and conditions provided to the employee prior to the death, or prior to the accident or injury that caused the death.

(b) Employees referenced above in Section 16.700(a), elected officials referenced above in Section 16.700(b), members of the San Francisco Unified School District referenced above in Section 16.700(d) and members of the San Francisco Community College District referenced above in Section 16.700(e) shall receive both the Charter-determined contribution and collectively bargained contributions. Notwithstanding the foregoing, employees referenced above in Section 16.700(a), who are not in active service for more than twelve (12) weeks, shall be required to pay the Health Service System for the full premium cost of membership in the Health Service System, unless the employee shall be on sick leave, workers' compensation, mandatory administrative leave, approved personal leave following family care leave, disciplinary suspensions or on a layoff holdover list where the employee verifies they have no alternative coverage. In accordance with the City's obligations under the Meyers-Milias-Brown Act, the Department of Human Resources shall establish rules and regulations

governing whether employees who, after inclusion in the system, work less than twenty (20) hours per week, shall lose eligibility in the system or whether the employee shall be required to make additional contributions to the system.

(c) Dependents of employees referenced above in Section 16.700(a) shall only receive collectively bargained contributions. Dependents of elected officials references above in Section 16.700(b) shall only receive contributions specified by ordinance. Dependents of members referenced above in Sections 16.700(d), (e) and (f) shall only receive the contributions specified by the appropriate governing body. Dependents of board and commission members referenced above in Section 16.700(c) shall receive no contribution. Dependents of retired employees referenced above in Section 16.700(g) shall receive contributions only as provided by the Charter.

(d) Resigned employees referenced above in Section 16.700(g) shall not receive any contribution.

(e) Those subgroups referenced above in Section 16.700(f) shall receive contributions as determined by their respective employers.

(Added by Ord. 48-95, App. 3/10/95; amended by Ord. 289-00, File No. 001549, App. 12/22/2000)

XLI. ADMINISTRATIVE CODE SECTION 16.702. – HEALTH SERVICE; BOARD COMPOSITION.

In any election for membership on the Health Service Board when only one candidate has filed nomination papers and no person has filed a declaration of write-in candidacy, the Director of Elections shall not conduct an election and shall declare the sole candidate to be a member of the Board.

(Added by Ord. 439-96, App. 11/8/96)

XLII. ADMINISTRATIVE CODE SECTION 16.704. – REMEDYING DISCRIMINATION AGAINST EMPLOYEES IN SAME-SEX MARRIAGES OR IN SAME-SEX DOMESTIC PARTNERSHIPS.

(a) Findings and Purpose. The City and County of San Francisco (City) finds that its own employees with same-sex spouses or same-sex domestic partners suffer both dignitary and economic harm as a result of discriminatory federal laws. In particular, as a result of discriminatory treatment under federal tax laws that impose taxes on health care coverage provided to employees with same-sex, but not those with opposite-sex, spouses, City employees with same-sex spouses or same-sex domestic partners suffer not only the indignities of being treated as second-class citizens by their own government; they also suffer measurable financial harm that is concrete, persistent, and significant, and in some cases immense.

The City is committed to the equitable principle that all City employees receive equal pay for equal work. That principle is unattainable for City employees with same-sex spouses or same-sex domestic partners so long as: (1) state law prevents same-sex couples from marrying; (2) federal law treats the value of employer contributions for same-sex spouses' or same-sex domestic partners' health insurance premiums as taxable income, and does not tax employer subsidies for opposite-sex spouses' health insurance premiums; and (3) federal law prevents the use of pre-tax dollars by employees to pay health insurance premiums for their same-sex spouses or same-sex domestic partners, while allowing the use of pre-tax dollars by employees to pay health insurance premiums for their opposite-sex spouses.

In an effort to offset the discriminatory impact of federal taxation on same-sex spouse and same sex-domestic partner health insurance premiums, and to come closer to achieving the equitable principle of equal pay for equal work, this Section 16.704 requires the City to make payments to City employees who are provided subsidies for,

and/or who pay all or part of the premiums for, their same-sex spouses' or same-sex domestic partners' health insurance premiums.

(b) For each City employee Health Service System member who is subject to federal taxation on health insurance premiums (both medical and dental) paid by the City for a same-sex spouse, or same-sex domestic partner, the City shall pay an amount equal to twenty (20%) percent of the portion of the employee's health insurance premiums attributable to the same-sex spouse, or same-sex partner, as determined by the San Francisco Health Service System. These payments shall not be part of the employee's base pay, are not payments made as compensation for hours of employment, and shall not be included in any overtime or premium pay calculations.

(c) Operative Date. This Section 16.704 shall become operative on July 1, 2013.

(d) Expiration. This Section 16.704 shall expire in its entirety, or as applied specifically to one or more of the following three groups of City employees – employees with same-sex spouses who married in California; employees with same-sex spouses who married outside of California; and employees with same-sex domestic partners – if, and when, the City Attorney's Office certifies to the Mayor and the Board of Supervisors that one or more of those groups of City employees are no longer subject to discriminatory federal income taxation of health insurance premiums attributable to their same-sex spouses or same-sex domestic partners. This Ordinance shall continue to apply to those groups of City employees listed above who continue to be subject to discriminatory federal income tax on health insurance premiums attributable to their same-sex spouses or same-sex domestic partners.

XLIII. ADMINISTRATIVE CODE SECTION 16.900. – ESTABLISHMENT OF A CAFETERIA PLAN.

The San Francisco Health Services System may establish an employee cafeteria plan as provided and regulated under Section 125 of Title 26 of the United States Internal Revenue Code.

(Added by Ord. 175-88, App. 4/28/88; amended by Ord. 370-88, App. 8/10/88; Ord. 105-00, File No. 000536, App. 5/26/2000; Ord. 3-12, File No. 111246, App. 1/12/2012, Eff. 2/11/2012)

XLIV. ADMINISTRATIVE CODE SECTION 16.901. – PURPOSE.

The purpose of this plan is to extend to employees of the City and County of San Francisco, San Francisco Unified School District, San Francisco Community College District, the Superior Court of California, County of San Francisco and the San Francisco County Transportation Authority (Participating Employers), those types of benefits that ordinarily accrue from participation in a cafeteria plan. The City and County of San Francisco does not and cannot represent or guarantee that any particular federal or state income, payroll or other tax consequence will occur by reason of an employee's participation in this plan. The participant should consult with his or her own attorney or other representative regarding all tax consequences of participation in this plan.

(Added by Ord. 175-88, App. 4/28/88; amended by Ord. 370-88, App. 8/10/88; Ord. 3-12, File No. 111246, App. 1/12/2012, Eff. 2/11/2012)

XLV.

ADMINISTRATIVE CODE SECTION 16.902. – ADMINISTRATION BY THE SAN FRANCISCO HEALTH SERVICE SYSTEM.

The cafeteria plan established pursuant to this Article may be administered by the San Francisco Health Service System which may prescribe such forms, and adopt such rules and regulations as are necessary to carry out the purposes of the plan. The San Francisco Health Service System shall also have the authority to amend the plan to ensure compliance with applicable laws and regulations, to reflect changes in benefit offerings by the City and County of San Francisco or Participating Employers, and to

make modifications for the reasonable administration of the plan. The San Francisco Health Service System may contract with a financially responsible independent contractor to administer and coordinate the plan.

(Added by Ord. 175-88, App. 4/28/88; amended by Ord. 370-88, App. 8/10/88; Ord. 105-00, File No. 000536, App. 5/26/2000; Ord. 3-12, File No. 111246, App. 1/12/2012, Eff. 2/11/2012)

XLVI. ADMINISTRATIVE CODE SECTION 16.903. – NO COST TO CITY AND COUNTY.

This cafeteria plan shall be administered free of direct cost to, or appropriation by, the City and County of San Francisco or the Participating Employers. Except as herein provided, all such costs shall be borne by the participants or by any plan administrator appointed hereunder, except to the extent that any subsequent ordinance or appropriation might provide expressly to the contrary. Nothing contained in this Section shall be deemed to prohibit the inclusion of a hold harmless provision in any contract between the City and any plan administrator appointed hereunder, which provision has been approved by the City's Risk Manager pursuant to Administrative Code Section 1.24.

(Added by Ord. 175-88, App. 4/28/88; amended by Ord. 370-88, App. 8/10/88; Ord. 105-00, File No. 000536, App. 5/26/2000; Ord. 3-12, File No. 111246, App. 1/12/2012, Eff. 2/11/2012)

XLVII. ADMINISTRATIVE CODE SECTION 16.904. – VOLUNTARY EMPLOYEE BENEFITS.

Based upon individual authorized deductions, the Controller is hereby authorized to deduct and collect monies from the salaries or wages of employees of the City and County of San Francisco, San Francisco Community College District, and the Superior Court of California, County of San Francisco, in accordance with San Francisco Administrative Code Sections 16.91 and 16.92. Pursuant to Section 125, this voluntary authorized deduction shall not be revocable by the employee during the cafeteria plan

year unless the revocation and new election are in conformance with Section 125 and the terms of the plan.

(Added by Ord. 370-88, App. 8/10/88; amended by Ord. 130-90, App. 4/12/90; Ord. 162-92, App. 6/10/92; Ord. 105-00, File No. 000536, App. 5/26/2000; Ord. 3-12, File No. 111246, App. 1/12/2012, Eff. 2/11/2012)

XLVIII.

ADMINISTRATIVE CODE SECTION 16.905. – CAFETERIA PLAN BENEFITS.

The Board of Supervisors hereby approves the inclusion of those benefit plans qualifying under the employee cafeteria plan as provided and regulated under Section 125 of Title 26 of the United States Code as well as the medical care plans adopted by the Health Service Board and approved by the Board of Supervisors annually under Section A8.422 of the Charter and Administrative Code Section 16.703 and which medical plans are on file with the Clerk of the Board of Supervisors.

(Added by Ord. 370-88, App. 8/10/88; amended by Ord. 130-90, App. 4/12/90; Ord. 162-92, App. 6/10/92; Ord. 105-00, File No. 000536, App. 5/26/2000; Ord. 3-12, File No. 111246, App. 1/12/2012, Eff. 2/11/2012)

XLIX. ADMINISTRATIVE CODE SECTION 16.906. – HEALTH SYSTEM MEMBERSHIP OF FORMER SUPERVISORS.

After leaving office as a member of the Board of Supervisors, a former Supervisor may still participate in any plan of the Health Service System, provided that the former Supervisor agrees to, and for so long as he or she does, pay the full cost of such benefit, as determined by the Health Service Board.

(Added by Ord. 13-91, App. 1/15/91)

L. ADMINISTRATIVE CODE SECTION 21.02. – DEFINITIONS.

As used in this Chapter the following words shall have the following respective meanings:

. . .

"Services" shall mean Professional Services and General Services. "Services" shall specifically exclude grants to a nonprofit entity to provide services to the community, which may include incidental purchases of commodities; legal and litigation related services or contracts entered into pursuant to settlement of legal proceedings; and services related to employee benefits, including, without limitation, health plans, retirement or deferred compensation benefits, insurance and flexible accounts, provided by or through the San Francisco Health Service System, the Retirement Board or the Retiree Health Care Trust Fund.

(Added by Ord. 156-99, File No. 990743, App. 6/2/99; amended by Ord. 9-11, File No. 101007, App. 1/7/2011; Ord. 3-12, File No. 111246, App. 1/12/2012, Eff. 2/11/2012; Ord. 46-15, File No. 131122, App. 4/17/2015, Eff. 5/17/2015; Ord. 108-15, File No. 150175, App. 7/2/2015, Eff. 8/1/2015)

San Francisco Health Service System Rules

Approved by the Health Service System Board on August 9, 2018 to
be effective January 1, 2019.

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A. HEALTH SERVICE SYSTEM MEMBER ELIGIBILITY

In accordance with City Charter Section 12.202, and San Francisco Administrative Code Section 16.700, the following persons shall be members of the San Francisco Health Service System. A member will be the primary enrolled subscriber for benefits offered through the Health Service System (HSS). Members are eligible to choose from the benefit plans provided by the Health Service System.

1. City & County of San Francisco Employees

- (1) All permanent employees of the City & County of San Francisco whose normal work week at the time of inclusion in the Health Service System is not less than twenty (20) hours;
- (2) All regularly scheduled provisional employees of the City & County of San Francisco whose normal work week at the time of inclusion in the Health Service System is not less than twenty (20) hours;
- (3) All other employees of the City & County of San Francisco, including “as needed” employees who have worked one thousand and forty (1,040) hours in any consecutive twelve (12) month period and whose normal work week at the time of inclusion in the Health Service System is not less than twenty (20) hours.
- (4) All other employees who are deemed ‘full-time employees’ under the shared responsibility provision of the Patient Protection and Affordability Care Act (section 4980H).

2. Elected Officials

All elected officials, including but not limited to:

- (1) the Mayor
- (2) the Board of Supervisors
- (3) the Assessor-Recorder
- (4) the Treasurer
- (5) the City Attorney
- (6) the Public Defender
- (7) the Sheriff

3. All Members of the Following Boards and Commissions During Their Time in Service with the City & County of San Francisco

- (1) Access Appeals Commission
- (2) Airport Commission
- (3) Arts Commission
- (4) Asian Art Commission

- (5) Board of Education
- (6) Board of Appeals
- (7) Building Inspection Commission
- (8) Civil Service Commission
- (9) Commission on the Aging
- (10) Commission on the Environment
- (11) Commission on the Status of Women
- (12) Community College District Governing Board
- (13) Concourse Authority
- (14) Elections Commission
- (15) Ethics Commission
- (16) Entertainment Commission
- (17) Fine Arts Museums Board of Trustees
- (18) Fire Commission
- (19) Film and Video Arts Commission
- (20) First Five Commission
- (21) Health Commission
- (22) Health Service Board
- (23) Historic Preservation Commission
- (24) Human Rights Commission
- (25) Human Services Commission
- (26) Juvenile Probation Commission
- (27) Law Library Board of Trustees
- (28) Library Commission
- (29) Municipal Transportation Authority
- (30) Planning Commission
- (31) Police Commission
- (32) Port Commission
- (33) Public Utilities Commission
- (34) Recreation and Parks Commission
- (35) Residential Rent Stabilization and Arbitration Board
- (36) Retirement Board
- (37) Small Business Commission
- (38) Sunshine Ordinance Task Force

- (39) Treasure Island Development Authority Board
 - (40) War Memorial and Performing Arts Center Board
 - (41) Youth Commission
4. **All Officers and Employees as Determined Eligible by the Governing Board of Education of the San Francisco Unified School District**
 5. **All Officers and Employees as Determined Eligible by the Governing Board of Education of the San Francisco Community College District**
 6. **All Officers and Employees as Determined Eligible by the Governing Bodies of the:**
 - (1) San Francisco Transportation Authority
 - (2) San Francisco Parking Authority
 - (3) San Francisco Redevelopment Agency
 - (4) Treasure Island Development Authority
 - (5) San Francisco Superior Court
 7. **Any Other Employees Not Listed in Sections A.1 –A.6, as Determined Eligible by Ordinance**
 8. **Retirees**

As used in these Rules, a Retiree Member is defined as a former employee member who leaves active employment after meeting his or her employer's requirements for retirement based on duration of service, disability or vesting and retires under his or her respective retirement system (SFERS, STRS, or PARS). To be eligible for participation in the Health Service System and to be eligible for health benefits at the premium contribution rate established for retirees (Section P), a Retiree Member must have elected to receive benefits under their retirement system and must have been enrolled in a health benefit plan through the Health Service System for some period during his or her term of employment with the City and County of San Francisco, the San Francisco Unified School District (SFUSD) or the San Francisco Community College District (SFCCD). SFUSD and SFCCD may impose additional requirements for health coverage.

If hired on or after January 10, 2009, a retiree is eligible to participate in the Health Service System, with no employer contributions toward health insurance premiums, after five (5) years of service. The Health Service System calculates service based on service with the Health Service System's participating employers – the City and County of San Francisco, the SFUSD, the SFCCD and the San

Francisco Superior Court. A retiree who retires for industrial disability does not have to meet the five year service requirement to be eligible for coverage.

9. Resigned Members

As used in these Rules, a Resigned Member is defined as an employee member who resigned and withdrew his or her funds from a retirement system within thirty (30) days immediately prior to the date on which, but for his or her resignation, he or she could have been retired for service as a member of a retirement system.

Coverage of a Resigned Member is at the unsubsidized full premium rate.

Coverage must be continuous and, if lapsed, may not be reinstated without Board approval. (See San Francisco City Charter Section A8.425 and Administrative Code 16.701(d).)

10. Former Elective Members of the Legislative Body

Members shall also include former elective members of the legislative body who have served in office after January 1, 1981, and whose total service at the time of termination of service on such legislative body is not less than twelve (12) years when the respective legislative body provides for the continuation of health benefits as authorized by Government Code Section 53201.

B. ELIGIBLE DEPENDENTS OF HEALTH SERVICE SYSTEM MEMBERS

If enrolled by a Health Service System member, the following dependents of a member shall be eligible for coverage subject to the following conditions and limitations:

1. A Member's Legal Spouse

- a.** A member's legal spouse may be enrolled within 30 days of marriage, during the open enrollment period or within 30 days of a qualifying event as defined in Section G. A member's legal spouse shall be eligible as a dependent of the member provided that the member files a copy of their marriage certificate, the spouse's Social Security number, and Medicare card (if applicable) with the Health Service System. Coverage shall be effective on the first day of the coverage period following the date in which HSS receives documentation.
- b.** When a member is granted a final dissolution of marriage or is legally separated, the member's former spouse shall not be eligible as a dependent as of the last day of the coverage period in which the legal separation, divorce or final dissolution has been granted. A member must immediately notify the Health Service System in writing and provide documentation when the legal separation, divorce or final dissolution of marriage has been granted. When a member has been granted a final dissolution of marriage, or is legally separated, coverage for his or her dependent children shall continue as long as they are otherwise eligible. However, coverage for stepchildren will not continue.

2. A Member's Legal Domestic Partner

- a. A domestic partner may be enrolled within 30 days of registration of domestic partnership, during open enrollment, or within 30 days of a qualifying event as defined in Section G. A domestic partner of a member shall be eligible as a dependent of a member if the member meets the following requirements:
- b. The member must provide to HSS a certification of domestic partnership that has been processed per the requirements of the issuing city or county:
 - (1) For members residing in San Francisco, domestic partnership must be established by filing the Declaration of Domestic Partnership with the San Francisco County Clerk. (Domestic Partnership registration completed through a notary public in San Francisco is not accepted by HSS.)
 - (2) Members residing in California (including San Francisco) may alternatively provide a California Secretary of State Certificate of Registration of Domestic Partnership. (See www.sos.ca.gov.)
 - (3) If the member resides in a city, county or state that does not issue certification of domestic partnership, then the member and his or her domestic partner must sign and submit a notarized Health Service System Declaration of Domestic Partnership form. The requirements for domestic partner eligibility in the Health Service System may be greater than what is required by a city or county for domestic partner registration.
 - (4) The member and his or her legal domestic partner must certify to the Health Service System that they are economically responsible to each other for the common necessities of life, defined as food, shelter and medical care, and that this shall remain the case for expenses incurred during the period the member's domestic partner is covered by the Health Service System.
 - (5) The domestic partner's Social Security number and Medicare card (if applicable) must also be provided to HSS. Coverage will be effective on the first day of the coverage period following the date in which HSS receives all documentation.
- c. When the member is granted dissolution of domestic partnership, is legally separated, or there is any change of circumstances as attested to in a Declaration of Domestic Partnership, the member's partner is no longer eligible as a dependent. A member must immediately notify the Health Service System in writing when the member's partner is not eligible. Failure to do so can result in termination of coverage and financial penalties. (See Section E.) Once a member's partner is no longer eligible, any children of the former partner are also no longer eligible.

3. Children

To be an eligible dependent child under these rules, a child must be one of the following and meet all other applicable criteria as stated in this Section B.3.

- (1) A natural child (up to age 26) of an enrolled member.
- (2) A legally adopted child, or child placed for adoption with, an enrolled member, (up to age 26).
- (3) A stepchild (up to age 26) who is a natural child of, a legally adopted child of, or a child placed for adoption with, a member's enrolled spouse or domestic partner.
- (4) A child (up to age 19) under the legal guardianship of a member, a member's spouse or a member's domestic partner
- (5) A member's child (up to age 19) as directed by court order.

a. Eligibility Requirements for Natural Children, Adopted Children, and Stepchildren

To be an eligible dependent child under these rules, a child must be under the age of 26 and one of the following:

- A natural child of an enrolled member.
- A legally adopted child of, or a child placed for adoption with, an enrolled member.
- A stepchild who is a natural child, legally adopted child, or child placed for adoption with, a member's enrolled spouse or domestic partner.

All of the following criteria are required:

- (1) A child may be enrolled within thirty (30) days of birth, adoption, or adoption placement date, during open enrollment, or within thirty (30) days of a qualifying event as defined in Section G;
- (2) A member must provide eligibility documentation for the child, including a birth certificate, adoption certificate or court documents, and a Social Security number;
- (3) No child of a member may remain, or be enrolled, in the Health Service System past the maximum age of 26 except a disabled child as provided in Section 3d below;
- (4) Coverage will become effective on the first day of the coverage period following the receipt of all documentation by HSS by required deadlines;
- (5) Recertification of eligibility may be required as determined by HSS.

b. Eligibility Requirements for Children Under Legal Guardianship

To be eligible, a child under legal guardianship of a member, a member's enrolled

spouse, or member's enrolled domestic partner, must meet all of the following criteria.

- (1) Child must be under 19 years of age;
- (2) Child may be enrolled within 30 days of the effective date of legal guardianship, during open enrollment, or within thirty (30) days of a qualifying event as defined in Section G.
- (3) The member must provide eligibility documentation, including a copy of the legal judgment or decree assigning legal guardianship and a Social Security number;
- (4) Coverage will become effective on the first day of the coverage period following the receipt of all documentation by HSS by required deadlines;
- (5) Recertification may be required as determined by HSS.
- (6) Grandchildren, nieces and nephews, the spouse of a member's child and other relatives or children of no family relation residing with a member are not eligible to be enrolled in an HSS administered health plan unless the child meets the qualifications for a child under legal guardianship.

c. Eligibility Requirements for Children Under Court Order

For the child to be eligible, a member must be required by judgment, decree or order issued by a court to provide health coverage for the child. All of the following criteria must be met:

- (1) Child must be under 19 years of age;
- (2) The member must provide HSS with a copy of the court order and the child's Social Security number;
- (3) Recertification may be required as determined by HSS.

d. Age Exemption for Eligible Adult Disabled Children

To qualify a dependent disabled adult child, the adult child must be incapable of self-support because of a mental or physical condition that existed prior to age 26, continuously live with disability after turning 26, and meet each of the following criteria: Disabled adult child ("Adult Child") is enrolled in a San Francisco Health Service System medical plan on the his or her 26th birthday; and

- (1) Adult Child has met the requirements of being an eligible dependent child under Section B.3 before turning 26 years old; and
- (2) Adult Child must have been physically or mentally disabled on the date coverage would have otherwise terminated due to age, i.e. turning 26 years old, and continue to be disabled from age 26 on; and
- (3) Adult Child is incapable of self-sustaining employment due to the physical or mental disability; and

- (4) Adult Child is dependent on HSS Member for substantially all of his or her economic support, and is declared as an exemption on the Member's federal income tax;
- (5) Member is required to comply with their enrolled medical plan's disabled dependent certification process and recertification process every year thereafter or upon request.
- (6) All enrolled dependents, including an Adult Child, who qualify for Medicare due to a disability are required to enroll in Medicare (See Section J). Members must notify HSS of any dependent's eligibility for Medicare, as well as any dependent's subsequent enrollment in Medicare.
- (7) To maintain ongoing eligibility after the Adult Child has been enrolled, the Member must re-enroll the Adult Child with HSS each year and must ensure that he or she remains continuously enrolled with Medicare A/B (if eligible) without interruption.

A newly hired employee who adds an eligible dependent Adult Child, who is age 26 or older, must meet all requirements listed, except d.(1) and d.(2) above and comply with their enrolled medical plan's disabled dependent certification process specified in d. (5) within (30) days of employee's hire date

4. Eligibility Requirements for Surviving Dependents

a. Surviving Spouse or Surviving Domestic Partner of an Active Employee Hired Before January 10, 2009

The surviving spouse or surviving domestic partner of an active employee hired before January 10, 2009 is eligible to enroll, provided that the surviving spouse or surviving domestic partner and the active employee had been married or registered as domestic partners for a period of at least one (1) year prior to the death of the active employee.

b. Surviving Spouse or Surviving Domestic Partner of an Active Employee Hired On or After January 10, 2009

1. The surviving spouse or surviving domestic partner of an active employee hired on or after January 10, 2009 is eligible to enroll if the deceased employee had accrued ten (10) or more years of credited service (as determined by HSS). The surviving spouse or surviving domestic partner and the active employee must have been married or registered as domestic partners for a period of at least one (1) year prior to the death of the active employee.
2. The surviving spouse or surviving domestic partner of an active employee hired on or after January 10, 2009, who died in the line of duty is eligible to enroll if the surviving spouse or surviving domestic partner is entitled to a death allowance as a result of the death in the line of duty. The surviving spouse or surviving domestic partner and the active employee must have been

married or registered as domestic partners for a period of at least one (1) year prior to the death of the active employee.

3. The surviving spouse or surviving domestic partner of an active member hired on or after January 10, 2009, who did not accrue ten (10) years of credited service (as determined by HSS) or who did not die in the line of duty with death allowance entitlement is not eligible.
4. The surviving spouse, or surviving domestic partner, and eligible dependent children of a firefighter or peace officer who died in the line of duty, is entitled to health benefits under the same terms and conditions provided prior to the death. (see Section 4856 of the California Labor Code).

c. Surviving Spouse or Surviving Domestic Partner of a Retired Member Hired Before January 10, 2009

The surviving spouse or surviving domestic partner of a Retiree Member who was hired before January 10, 2009 is eligible to enroll provided that the surviving spouse or surviving domestic partner and the Retiree Member have been married or registered as domestic partners for a period of at least one (1) year prior to the death of the Retiree Member.

d. Surviving Spouse or Surviving Domestic Partner of a Retired Member Hired On or After January 10, 2009

1. The surviving spouse or surviving domestic partner of a Retiree Member who was hired on or after January 10, 2009 is eligible to enroll if the deceased member had accrued ten (10) or more years of credited service (as determined by HSS), and retired within 180 days of separation from employment. The surviving spouse or surviving domestic partner and the retired member must have been married or registered as domestic partners for a period of at least one (1) year prior to the death of the Retiree Member.
2. The surviving spouse or surviving domestic partner of a deceased Retiree Member who was hired on or after January 10, 2009, and who retired with a disability retirement from their retirement system, is eligible to enroll if the surviving spouse or the surviving domestic partner and the Retiree Member were married or registered as domestic partners for a period of at least one year prior to the death of the retiree member.
3. The surviving spouse or surviving domestic partner of a Retiree Member hired on or after January 10, 2009, who did not accrue ten (10) years of credited service (as determined by HSS), or did not retire within 180 days of separation from employment, is not eligible.

e. Eligibility Requirements for Surviving Dependent Children

Surviving dependent children of an active employee or Retiree Member must have been enrolled on the member's coverage at the time of the member's death, must meet eligibility requirements in B.3, and are only eligible for benefits under a surviving spouse member or a surviving domestic partner member.

f. Additional Surviving Dependent Enrollment Requirements

- (1) The surviving spouse or surviving domestic partner of a deceased Resigned Member is not eligible.
- (2) Because they are dependents themselves, surviving spouses and surviving domestic partners do not have the member privilege of enrolling any individuals as additional dependents on their coverage. A surviving dependent cannot enroll additional dependents, including children not enrolled at the time of the member's death, or a new spouse or domestic partner.
- (3) Eligible surviving dependents may continue enrollment if they complete the surviving dependent enrollment process within thirty (30) days of a member's death. They may continue to be enrolled as long as they remain eligible. An eligible surviving spouse or domestic partner not enrolled within thirty (30) days of the member's death is eligible for coverage but must wait for the next open enrollment period or other qualifying event.
- (4) Surviving dependents of a firefighter or peace officer killed in the line of duty are eligible for subsidized benefits at the active rate unless a lump sum survivor's benefit is elected (*section 4856 of the State of California Labor Code*).
- (5) See Section P for rules regarding surviving dependent premium contributions, employer subsidy and delinquency.

C. ELIGIBILITY DOCUMENTATION REQUIRED

1. Members

All members are required to provide eligibility documentation as requested by the Health Service System and as required under federal, state or local law. Failure to provide eligibility documentation as required shall result in termination of coverage.

2. Dependents, Including Eligible Spouses, Domestic Partners, Children and Surviving Dependents

The Health Service System may require proof of dependent eligibility at any time. Failure to furnish such proof within thirty (30) days after a request by the Health

Service System shall result in termination of coverage. Re-enrollment may occur during annual open enrollment, with coverage effective the first day of the following plan year, upon submission to the Health Service System of a completed enrollment application and required eligibility documentation.

3. Social Security Numbers Required

All members are required to provide the Health Service System with Social Security numbers for themselves and all enrolled dependents. The failure to provide Social Security numbers will result in the termination of health coverage administered by the Health Service System. Exceptions can be made on a case-by-case basis for members and dependents who do not qualify for Social Security numbers upon approval of the Health Service System Director.

4. Member Addresses Required

All members are required to keep a current residential and mailing address on file with the Health Service System. Members must report address changes to the Health Service System within thirty (30) days. Members are responsible for promptly responding to notices mailed by the Health Service System to the address on file with HSS. Health care coverage may be terminated for members who do not keep their address and contact information updated at HSS. The Health Service System will document a minimum of five attempts over a period of two years to contact a member whose address and contact information on file with the Health Service System is incorrect. After five attempts, the member's health benefits will be terminated. A member terminated for failure to keep current his or her address and contact information may seek reinstatement during the next open enrollment period.

D. TAXATION OF HEALTH BENEFITS OF A DOMESTIC PARTNER

Premium contributions for the domestic partner's health coverage may or may not be eligible for pre-tax treatment contingent on applicable federal and state income tax law. Thus, coverage of the domestic partner dependent could result in additional imputed income to the member, with possible withholding for payroll taxes, including income and Social Security taxes, on such amounts.

Members who file a *Declaration That Enrolled Dependent Meets IRS Standard For Pre-Tax Health Premium Deduction* form with HSS will pay member health premium contributions for the domestic partner and/or the partner's children on a pre-tax basis effective the first day of the coverage period following the date in which HSS receives the form. Imputed income will not accrue for the employer's portion of premium contributions for qualifying dependents.

Changes in a dependents tax status cannot be made retroactively. An Annual declaration must be filed for each qualifying dependent.

E. MEMBER RESPONSIBILITY TO NOTIFY HEALTH SERVICE SYSTEM WHEN A DEPENDENT BECOMES INELIGIBLE

It is the responsibility of the member to provide immediate written notification to the Health Service System when canceling coverage for any dependent who no longer meets the conditions for eligibility. There shall be no obligation on the part of the Health Service System to provide health coverage to, or refund contributions made on account of, an ineligible dependent. If a member fails to notify the Health Service System when an enrolled dependent becomes ineligible the member may be held responsible for payment of all health premium costs, including but not limited to any employer premium costs and costs for medical services provided, dating back to the date of the dependent's ineligibility.

Dependent eligibility may be audited by HSS at any time. Enrollment of a dependent who does not meet the plan's eligibility requirements as stated in Health Service System Rules and enrollment materials, or failure to disenroll when a dependent becomes ineligible, will be treated as an intentional misrepresentation of a material fact, or fraud.

F. OPEN ENROLLMENT PERIOD

The Health Service System shall conduct an annual open enrollment for a period of three to four weeks as approved by the Health Service Board.

1. A member may change benefit plan elections, and add or cancel dependents during open enrollment.
2. A member must submit all required enrollment applications and eligibility documentation by the open enrollment due date established by the Health Service System.
3. A retiree may waive medical coverage at any time. A retiree may only waive dental coverage for themselves and enrolled dependents during open enrollment, unless there is a qualifying event. (See Section G.)
4. Dependents that are deleted from coverage during open enrollment are not eligible for COBRA continuation coverage.
5. All changes made during the annual open enrollment period shall be effective on the first day of the following plan year.
6. If no changes are elected during open enrollment, current medical, dental and vision plan elections and enrolled dependents will remain the same.
7. Flexible Spending Accounts (FSAs) require annual enrollment. HSS administers a Child Care Dependent Care FSA and a Healthcare FSA with Carryover. Carryover allows unused health FSA balance of a \$10 minimum up to a \$500 maximum to be carried forward for one plan year after which any remaining carryover funds will be forfeited. The health FSA carryover option (from \$10 to \$500) is independent of the annual FSA election requirement. Child Care Dependent Care FSA does not have a Carryover provision.

G. QUALIFYING STATUS CHANGES AND OTHER APPLICABLE EVENTS FOR CHANGING BENEFIT ELECTIONS OUTSIDE OF THE OPEN ENROLLMENT PERIOD

For enrollments due to a qualifying change in status, or other qualifying applicable event, the member must notify the Health Service System and complete the enrollment process, including the submission of all required eligibility documentation, no later than thirty (30) calendar days after the qualifying event.

A member may make a benefit election change, healthcare and/or dependent care Flexible Spending Account (FSA) change due to a qualifying status change a maximum of twice per plan year.

The following qualifying status changes, or other applicable events, allow a member to make benefit election changes, healthcare and/or dependent care Flexible Spending Account (FSA) changes outside of open enrollment so long as the election change is a result of and consistent with, the change in status.

1. Change in Legal Marital or Partnership Status

a. Marriage

A member's marriage allows the member to add his or her new spouse and eligible stepchildren, as defined in Section B.3., to his or her existing HSS coverage or, in the alternative, drop his or her existing HSS coverage by joining the spouse's employer coverage and providing Proof of Coverage on spouse's coverage within 30 days of the coverage's effective date.

b. Domestic Partnership

A member's domestic partnership allows the member to add his or her new partner and eligible stepchildren, as defined in Section B.3., to his or her existing coverage or, in the alternative, drop his or her HSS coverage by joining the domestic partner's employer coverage and providing Proof of Coverage on domestic partner's coverage within 30 days of the coverage's effective date.

c. Divorce, Legal Separation, Annulment or Dissolution of Partnership

In the event of divorce, legal separation, annulment or dissolution of domestic partnership, a member must immediately terminate health coverage for the ex-spouse or domestic partner and any accompanying covered stepchildren. A member will be responsible for the full cost of all health premiums back to the date of the dependent's ineligibility for failure to terminate health coverage within 30 days for the ex-spouse, domestic partner or any accompanying covered stepchildren. See Section E.

2. Change in Number of Dependents

a. Birth

The birth of a child allows the member to add the child to his or her existing coverage.

b. Adoption and Placement for Adoption

The adoption and placement for adoption of a child allows the member to add the child to his or her existing coverage.

c. Legal Guardianship

If an enrolled member, or the member's spouse or domestic partner, assumes legal guardianship of a child, the member may add the child to his or her existing coverage outside of open enrollment.

d. Court Order

If a court orders an enrolled member to provide health coverage for a child, the member may add the child to his or her existing coverage outside of open enrollment. The member may also cancel health coverage if the court orders

coverage to be provided by someone else. Dependent care Flexible Spending Account contributions cannot be modified due to this status change.

3. Change in the Employment Status of Spouse, Domestic Partner, or Other Dependent

a. Loss of Other Coverage

Members and eligible dependents that lose other coverage may be enrolled in Health Service System coverage. Proof of loss of coverage must be provided by the HSS member.

(1) Termination of Employment

If a member or eligible dependent loses other coverage due to employment termination, the member may enroll his or herself, and/or the member's spouse, domestic partner, and any affected eligible children, in HSS health coverage within thirty (30) days of the loss of coverage. Proof of loss of coverage is required. The member also has the option of initiating or modifying healthcare and dependent care Flexible Spending Account contributions.

(2) Change from Full-Time to Part-Time Employment

If a member or enrolled dependent loses other coverage, or cannot afford other coverage, due to a change from full-time to part-time employment, the member may enroll his or her self, and the member's spouse, domestic partner and any affected eligible children, within thirty (30) days of the change in employment status. Proof of loss of coverage is required. The member also has the option of initiating or modifying healthcare and dependent care Flexible Spending Account contributions.

(3) Open Enrollment Under Dependent's Employer

If a dependent drops coverage during his or her employer's open enrollment period, the member may add his or her self, spouse, domestic partner and any affected eligible children, to HSS health coverage within thirty (30) days of the loss of coverage. Proof of loss of coverage is required. The member also has the option of initiating or modifying dependent care Flexible Spending Account contributions. Healthcare Flexible Spending Account contributions cannot be modified.

(4) Commencement of an Unpaid Leave of Absence

If a dependent loses other coverage due to an unpaid leave of absence, the member may enroll the spouse, domestic partner and any affected eligible children, on HSS health coverage within thirty (30) days of the loss of coverage. Proof of loss of coverage is required. The member also has the option of initiating or modifying healthcare and dependent care Flexible Spending Account contributions.

(5) Loss of Medicare or Medicaid

If a member or eligible dependent loses other coverage due to ineligibility for Medicare or Medicaid, that individual may be enrolled on HSS health coverage within thirty (30) days of the loss of coverage. Proof of loss of coverage is required. The member also has the option of initiating or modifying healthcare Flexible Spending account contributions. Dependent care Flexible Spending Account contributions cannot be modified due to this status change.

b. Gain of Other Coverage

Members and eligible dependents that gain other coverage may be disenrolled from Health Service System coverage. Proof of gain of other coverage must be provided by the HSS member.

(1) Commencement of Employment

If an enrolled dependent gains other coverage due to new employment, the member may waive HSS coverage for his or her self, and/or drop dependent(s) from HSS coverage within thirty (30) days of the date the other coverage begins. (If member waives coverage, dependent coverage must also be dropped.) Proof of gain of other coverage is required. The member also has the option of modifying healthcare and dependent care Flexible Spending Account contributions.

(2) Change from Part-Time to Full-Time Employment

If an enrolled member or dependent gains other coverage due to the dependent's change from part-time to full-time employment, the member may waive coverage for his or her self, and/or drop dependent(s) from HSS coverage, within thirty (30) days of the date other coverage begins. (If member waives coverage, dependent coverage must also be dropped.) Proof of gain of other coverage is required. The member also has the option of modifying healthcare and dependent care Flexible Spending Account contributions.

(3) Open Enrollment Under Dependent's Employer

If an enrolled member or dependent gains other coverage during the open enrollment period of the dependent's employer, the member may drop waiver coverage for his or her self, and/or drop dependent(s) from HSS coverage within thirty (30) days of the date other coverage begins. (If member waives coverage, dependent coverage must also be dropped.) Proof of gain of coverage is required. The member also has the option of modifying dependent care Flexible Spending Account contributions. Healthcare Flexible Spending Account contributions cannot be changed due to this status change.

(4) Return From an Unpaid Leave of Absence

If an enrolled member or dependent gains other coverage upon the dependent's return from an unpaid leave-of-absence, the member may waive coverage for his or her self, and or drop dependent(s) from coverage within thirty (30) days of the date other coverage begins. Proof of gain of other coverage is required. The member also has the option of modifying healthcare and dependent care Flexible Spending Account contributions.

(5) Entitlement to Medicare or Medicaid

If the member or dependent gains other coverage due to eligibility for Medicare or Medicaid, the member may waive coverage for his or her self, and drop dependents from HSS coverage, consistent with the entitlement change. Proof of gain of Medicare or Medicaid coverage is required. The member also has the option of modifying healthcare Flexible Spending Account contributions. Dependent care Flexible Spending Account contributions cannot be changed due to this status change.

4. An Active Employee Member May Drop Coverage for Self or Dependents Outside of Open Enrollment Only with Proof of Other Coverage that was effective within the last 30 days

5. A Retiree Member May Waive Medical Coverage for Self or Dependents at Any Time Outside of Open Enrollment by Submitting Required Forms to HSS

If a Retiree Member waives coverage, he or she may not re-enroll self or dependents until the next open enrollment or outside of open enrollment if there is a qualifying event as defined in Section G. (Retirees may not waive dental coverage outside of open enrollment unless there is a qualifying event as defined in Section G.)

6. A Surviving Dependent May Waive Medical Coverage for Self or Dependents at Any Time Outside of Open Enrollment by Submitting Required Forms to HSS

If surviving spouse or domestic partner waives coverage, he or she may not re-enroll until the next open enrollment, or if there is a qualifying event as defined in Section G. If coverage is waived for surviving eligible children those children cannot be re-enrolled.

7. Significant Change in Health Coverage During a Plan Year

If there is a mid-year change in coverage such as a substantial decrease in medical providers under a plan, or a significant increase in deductible, copayment or out-of-pocket limits, the Health Service Board may direct HSS to allow mid-year plan changes due to this applicable event. When so directed, a member may elect to drop HSS coverage or change HSS coverage options.

Healthcare Flexible Spending Account contributions cannot be changed due to this status change.

8. Dependent Care Flexible Spending Accounts: Significant Change in Dependent Care Costs

If there is a significant increase or decrease in the cost for dependent care, the member may increase or decrease dependent care flexible spending contributions. This is allowed only if the cost change is required by a dependent care provider who is not a relative of the member. Proof of cost change is required.

H. TRANSFER OF HEALTH BENEFIT PLANS

The application to change from one health benefit plan to another may be made only during the annual open enrollment period each year with coverage to become effective the first day of the following plan year, unless otherwise provided for by these Rules.

1. Members Moving Primary Residence Outside a Health Benefit Plan Service Area

Members who move their primary residence to a location outside their health plan's service area will no longer be able to obtain services through that plan. Members will need to enroll in a different HSS plan that offers services based on the new primary address. A member must complete an HSS application to elect a new plan within thirty (30) days of his or her move. Coverage in the new plan will be effective the first day of the coverage period following the date HSS receives the completed enrollment application. Coverage will be terminated for active employee members who move their primary residence outside their health plans service area and do not enroll in a new plan within thirty (30) days of their move. Retiree Members who move their primary residence outside the service area of their health plan service area and do not enroll in a new plan in thirty (30) days will automatically be moved to City Health Plan.

2. Members Residing Temporarily Outside a Health Benefit Plan Service Area for Six or More Months

A member who is leaving the area of service of a health benefit plan temporarily for a period in excess of six (6) months may apply for a transfer to a health benefit plan servicing the area of residence. Application must be submitted to the Health Service System in writing at least thirty (30) days prior to the member's leaving the service area of the current plan. Transfer into the new health benefit plan shall become effective on the first day of the coverage period after such application is received by Health Service System. A member may return to the original health benefit plan, if written application to the Health Service System is made within thirty (30) days of return to the area of service.

3. Retirees Establishing Permanent Residence Outside of the United States

- a. Retiree Members and dependents, regardless of health benefit plan, who reside outside of the United States are required to enroll in the City Health Plan or temporarily waive coverage.
- b. Medicare enrollment is not required for members residing outside the United States; however, services within the United States will not be covered if Medicare enrollment is waived or discontinued. Members will be required to complete an HSS form certifying that they are waiving Medicare enrollment. and waiving health coverage within the United States.
- c. For retired members and dependents who reside outside the United States and continue their Medicare enrollment, services within the United States will be covered. Services outside the United States will be paid at the out-of-area reimbursement rate.
- d. Applications must be made thirty (30) days in advance of leaving the United States. Members who establish permanent residency outside the United States may retain coverage and must make the required premium payments directly to the Health Service System by the applicable due dates.

4. Members Enrolled in a Discontinued Health Benefit Plan

Members of a health benefit plan discontinued during the benefit year will be provided a special enrollment period to select an alternative health benefit plan. A member who does not enroll in an alternate health benefit plan during the special enrollment period will automatically be enrolled in the City Health Plan.

5. School Term Employees

School term employees of the San Francisco Unified School District or San Francisco Community College District may not transfer plans, or add dependents to their existing plans, during the open enrollment period unless they continue group coverage for the summer months.

6. Entitlement to Medicare

If a retired member or their dependent becomes entitled to Medicare, the member or dependent will need to transfer to a Medicare Advantage Plan in order to maintain HSS coverage if no Medicare Advantage and Medicare Prescription Drug Plan is available in their pre-Medicare plan. (See Section J & K)

I. CONTINUATION OF HEALTH BENEFITS COVERAGE AFTER RETIREMENT

1. Service, Disability or Vesting Retirement for Members Who Have Been Enrolled in Health Service System Health Benefit Plans While Actively Employed

A member who retires for service, disability or vesting may continue coverage through the Health Service System at the rate established for retired employees, provided he or she applies for continuation of coverage within thirty (30) days after such retirement is approved by his or her retirement system. Thereafter, application for enrollment may be made only during open enrollment, with coverage to become effective the first day of the following plan year. In addition to Health Service System requirements, San Francisco Unified School District and San Francisco Community College District employees must meet their employer's respective eligibility requirements. To be eligible for health benefits at the premium contribution rate established for retirees, a member must have been enrolled in a health benefit plan through the Health Service System for some period during his or her term of employment with the City & County of San Francisco, the San Francisco Unified School District or the San Francisco Community College District.

2. Service, Disability or Vesting Retirement for Members Who Have Not Been Enrolled in Health Service System Health Benefit Plans While Actively Employed

Per City Charter Section A8.428, an individual who would qualify for coverage under Section I.1. above, but for the fact that he or she has never been enrolled in a health benefit plan through the Health Service System for some period during his or her term of employment with the City & County of San Francisco, San Francisco Unified School District or San Francisco Community College District, may enroll in a health benefit plan as described in Section I.1., except that he or she shall pay the full, unsubsidized rate. The full, unsubsidized rate is the total premium paid to the health plan consisting of both the retiree contribution and the employer contribution.

3. Resigned Retiree Members

A member who resigned, and withdrew his or her funds from a retirement system within thirty (30) days immediately prior to the date on which, but for his or her resignation, he or she could have been retired for service as a member of a retirement system, may continue coverage at the full unsubsidized rate for resigned employees as established by the Health Service Board under the provisions of Charter Section A8.425. A Resigned Member also includes teachers who moved funds from the San Francisco Employees Retirement System (SFERS) to the State Teachers Retirement System (STRS). Such Resigned Members must apply for

continuation of coverage within thirty (30) days after resignation. Such Resigned Members (including surviving spouse dependents) must make arrangements to pay contributions monthly in advance to the Health Service System by the applicable due dates. Coverage of a Resigned Member must be continuous and, if lapsed, cannot be reinstated without Health Service Board approval.

4. Retiree Premium Contribution Payments Required

If sufficient funds are available, the Health Service System requires all premium payments to be deducted from the retiree member's pension check. If sufficient funds are not available, the retiree must make required premium contributions directly to the Health Service System by applicable due dates. Failure to make premium contributions by the applicable due dates may result in termination of coverage.

5. Retiree Must Notify the Health Service System of Current Primary Address

A retiree member who is enrolled in a Health Service System administered health benefit plan must maintain his or her correct primary residential address on file with the Health Service System and notify the Health Service System within thirty (30) days of any primary address change. Change in primary residence may require a change in health plan. A retiree who becomes ineligible for coverage because he or she moves outside of the plan's service area may be required by the plan to pay for all services received while ineligible.

Health care coverage may be terminated for members who do not keep their address and contact information updated at HSS. The Health Service System will document a minimum of five attempts over a period of two years to contact a member whose address and contact information on file with the Health Service System is incorrect. After five attempts, the members' health benefits will be terminated. A member terminated for failure to keep current his or her address and contact information may seek reinstatement during the next open enrollment period.

J. REQUIRED MEDICARE ENROLLMENT

Medicare is a federal health insurance program for people age 65 years or older, under age 65 with a Social Security-qualified disability, and people of any age with End-Stage Renal Disease. The different parts of Medicare help cover specific services: Part A covers hospital insurance; Part B covers medical insurance; and Part D covers prescription drug insurance. (See medicare.gov.)

1. Active Employee Members Age 65 and Over

All active employees over the age of 65 have the option, but are not required, to enroll in non-contributory Medicare Part A and contributory Medicare Part B as soon as they are eligible.

2. Dependents of Active Employee Members

Subject to CMS rules, all married spouses, natural children, step children, adopted children or children under legal guardianship of an active member who are Medicare-eligible due to either age or disability, have the option, but are not required, to enroll in non-contributory Medicare Part A and contributory Medicare Part B as soon as they are eligible.

Subject to CMS Rules, all domestic partner dependents of active employee members who are Medicare-eligible must enroll in both non-contributory Medicare Part A and contributory Medicare Part B as soon as they become eligible. (Some dependents will only qualify for Medicare Part B.) If an active employee member's domestic partner is Medicare-eligible but fails to enroll in either non-contributory Medicare Part A or contributory Medicare Part B that dependent's HSS medical coverage will be terminated.

3. Retiree Members

Retiree Members who are Medicare-eligible due to either age or disability must enroll in both non-contributory Medicare Part A and contributory Medicare Part B. (Some retired members will only qualify for Medicare Part B.) It is the responsibility of the member to notify the Health Service System of Medicare eligibility and enrollment. A Retiree Member who is eligible but fails to enroll in both non-contributory Part A and in contributory Part B of Medicare, will be automatically transferred to the City Health Plan 20 until proof of Medicare enrollment is provided. City Plan 20 provides coverage at a higher out-of-pocket cost to the Retiree Member.

4. Dependents of Retiree Members

All dependents of Retiree Members who are eligible due to either age or disability must enroll in both non-contributory Medicare Part A and contributory Medicare Part B. If a dependent is eligible but fails to enroll in either non-contributory Part A or contributory Part B of Medicare that dependent's coverage will be terminated. (Some dependents will only be eligible for Medicare Part B.)

K. MEDICARE ADVANTAGE ENROLLMENT

Medicare Advantage and Medicare Prescription Drug program (MAPD) participation is required for all Medicare-eligible Retiree Members and dependents who are enrolled in a plan administered by HSS. Retiree Members who fail to maintain enrollment in non-contributory Medicare Part A, Medicare Part B or Medicare Part D will need to waive their

coverage or will be automatically transferred to the City Health Plan 20. City Plan 20 provides coverage at a higher out-of-pocket cost to the Retiree Member. (See Section J.)

L. DUAL HEALTH PLAN COVERAGE RESTRICTIONS

1. No Dual Health Service System Coverage

Health Service System members and their dependents cannot be enrolled in two administered medical or dental plans at the same time. In other words, members may not be enrolled in an HSS-administered plan or plans both as a member and as a dependent of another member. If dual enrollment elections are submitted, HSS will automatically eliminate dual coverage as follows:

- a. For any member who is covered both as a member and as a dependent of another member, coverage as a dependent will be terminated.
- b. For dependents who are covered by two different HSS members, the dependent(s) will be covered by the member who covered the dependent(s) first based on date of enrollment.

2. No Dual Medicare Coverage

- 3. For the HSS Medicare Advantage or Medicare-sponsored plans, members and their dependents enrolled in these plans cannot be simultaneously enrolled in a non-HSS administered Medicare plan. Medicare will allow only the most recent enrollment to apply and will require disenrollment from the prior plan. Other non-Medicare Dual Coverage Must Be Disclosed to the Health Service System.**

Health Service System members are required to disclose to HSS dual health plan coverage for the member and any enrolled dependents. Other medical or dental coverage through a spouse or domestic partner's employer, the Veterans Administration, Tricare or other government health program, a retirement benefit from a previous employer, or a second employer must be disclosed to HSS during open enrollment and with any mid-year status changes.

M. MEMBER HEALTH BENEFITS COVERAGE PERIODS

1. Coverage Effective Date

Coverage shall be effective as set forth below. See Appendix A for coverage period schedules for the current plan year.

a. Eligible Permanent, Provisional and Temporary Exempt Employees of the City & County of San Francisco and Other Designated Employers

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
1 st thru 31 st	1st day of the following coverage period
Health and Dependent Care Flexible Spending Accounts	1st day of the following coverage period

b. Eligible Commissioners of the City & County of San Francisco

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
1 st thru 31 st	1 st day of the following coverage period

c. Eligible Employees of the San Francisco Unified School District

(i) Monthly

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
1 st thru 31 st	1 st day of the following coverage period

(ii) Bi-Weekly

COVERAGE EFFECTIVE DATE
First day of the pay period following the Eligibility Event Date

d. Eligible Employees of the San Francisco Community College District

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
1 st thru 15 th	16 th of that month
16 th thru 31 st	1 st day of the following coverage period

2. Coverage Termination Date

Coverage shall terminate as set forth below:

a. Eligible Permanent, Provisional and Temporary Exempt Employees of the City & County of San Francisco and Other Designated Employers

ELIGIBILITY EVENT DATE	COVERAGE TERMINATION DATE
1 st thru 31 st	Last day of the coverage period for which the employee premium contributions have been made in full
Health and Dependent Care Flexible Spending Accounts	Last day of the coverage period for which the employee premium contributions have been made in full

b. Eligible Commissioners of the City & County of San Francisco

ELIGIBILITY EVENT DATE	COVERAGE TERMINATION DATE
1 st thru 31 st	Last day of the coverage period for which the employee premium contributions have been made in full

c. Eligible Employees of the San Francisco Unified School District

(i) Monthly

ELIGIBILITY EVENT DATE	COVERAGE TERMINATION DATE
1 st thru 31 st	Last day of the coverage period for which the employee premium contributions have been made in full

(ii) Bi-Weekly

COVERAGE TERMINATION DATE
Last day of the pay period following the eligibility event date

d. Eligible Employees of the San Francisco Community College District

ELIGIBILITY EVENT DATE	COVERAGE TERMINATION DATE
1 st thru 15 th	15 th of that month
16 th thru 31 st	Last day of the coverage period for which the employee premium contributions have been made in full

e. Termination Date for Deceased Eligible Members

COVERAGE TERMINATION DATE
Coverage terminated as of the day after death

N. DEPENDENT HEALTH BENEFITS COVERAGE PERIODS

1. Coverage Effective Dates

Eligibility qualification requires submission of completed application form and other required documentation to the Health Service System within thirty (30) days of a qualifying event. Coverage shall be effective as set forth below. See Appendix A for coverage period schedules for the current plan year.

a. Eligible Dependents

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
At the time of member's original enrollment	1 st day of the coverage period after a completed application is filed with the Health Service System

A member may enroll his eligible dependents at the time of original enrollment. Coverage for eligible dependents becomes effective on the same day as the member. However, a dependent that is hospital-confined at the time of the member's original eligibility shall be added effective on the date he or she is no longer hospital confined. Eligibility documentation is required.

b. Eligible Spouses, or Domestic Partners, and Other Eligible Dependents Acquired By Marriage or Domestic Partnership

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
Within 30 days after the date of marriage or domestic partnership	1 st day of the coverage period after a completed application is filed with the Health Service System

An active employee or Retiree Member, who marries or enters into a domestic partnership after becoming a member, may enroll his or her spouse or domestic partner and other eligible dependents acquired by marriage or domestic partnership. Enrollment is to be made within thirty (30) days after the date of marriage or domestic partnership, and coverage for eligible dependents so enrolled shall become effective as of the 1st day of the coverage period after a completed application is filed with Health Service System. However, a hospital-confined dependent shall be added effective the date he or she is no longer hospital confined. Documentation of marriage or domestic partnership is required.

c. Eligible Newborns

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
Within 30 days after birth or commencement of legal custody	The date of birth as long as a completed application is filed with the Health Service System within thirty (30) days of the date of birth

A member's newborn child must be enrolled in the Health Service System to have coverage, provided such enrollment is made within thirty (30) days after birth. Such enrollment shall be made by application to the Health Service System, and shall be effective from the date of birth. Documentation of birth is required.

d. Eligible Adopted Children and Children Placed for Adoption

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
Within 30 days of the commencement of legal custody or placement	The commencement of legal custody as long as a completed application is filed with the Health Service System within thirty (30) days of the date of adoption

An adopted child of a member (or member's spouse or domestic partner) may be enrolled, provided such enrollment is made within thirty (30) days of commencement of legal custody. Such enrollment shall be made by application to the Health Service System, and shall be effective from the date on which such legal custody commenced. Documentation of adoption is required.

e. Limited Exceptions for Newborn and Adopted Child Enrollments

Notwithstanding the foregoing, after the expiration of the applicable period of thirty (30) days set forth in Sections N.1.c. and N.1.d. above, the Health Service System Director may permit the enrollment of a newborn child or a newly adopted child into a medical benefit plan offered by the Health Service System upon satisfaction of each of the following conditions:

- (1) The Director has found that the member has acted in good faith and not in willful violation of the rules contained in Sections N.1.c. and N.1.d. above;
- (2) The child's membership will be effective on the date of birth or the date of commencement of legal custody, as the case may be;

- (3) The Health Service System receives full payment of all premiums (both employer-paid and member-paid portions) required to enroll the child for the period from such effective date through the end of the current coverage period;
- (4) To comply with agreements established with the health benefit plan vendors, newborns must be enrolled within six (6) months of the date of birth to be eligible for coverage.

f. Eligible Dependent Children for Whom the Member (or Member’s Spouse or Domestic Partner) Has Assumed Legal Guardianship

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
Within 30 days of commencement of legal guardianship	1 st day of the coverage period after a completed application is filed with the Health Service System

An eligible dependent child of whom the member (or member’s spouse or domestic partner) has assumed legal custody may be enrolled provided such enrollment is made within thirty (30) days of commencement of legal custody. Such enrollment shall be made by application to the Health Service System, and shall be effective the first day of the coverage period after a completed application is filed with the Health Service System. Documentation of eligibility is required.

g. Other Eligible Dependents Who Have Entered the United States or Have Moved Into The Service Area of the Member’s Health Benefit Plan

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
Within 30 days of the date the dependent changes his or her primary residence	1 st day of the coverage period after a completed application is filed with the Health Service System.

Other eligible dependents who have either entered the United States or have moved into the service area of the member’s health benefit plan may be enrolled provided such enrollment is made within thirty (30) days of the date the dependent changes his or her primary residence. Coverage will be effective on the first day of the coverage period after a completed application is filed with the Health Service System. Documentation is required.

h. Eligible Dependents Who Lose Group Health Insurance Coverage Through Job Displacement

ELIGIBILITY EVENT DATE	COVERAGE EFFECTIVE DATE
Within 30 days of the last date of group coverage under another employer.	1 st day of the coverage period after a completed application is filed with the Health Service System

Eligible dependents who lose group health insurance coverage through job displacement may apply for coverage through the Health Service System within thirty (30) days of the last date of group coverage under another employer. Such application for coverage requires a letter from the former employer or former health benefit plan vendor stating the reason for lost coverage and the last date of coverage. The approval or rejection of the application and effective date of any coverage other than listed above is subject to the discretion of the Health Service System.

i. Open Enrollment Coverage Effective Date

Dependents not enrolled by the member at the time of the member's enrollment, or within the applicable periods of eligibility as described in this Section M. may thereafter be enrolled only during open enrollment with coverage to be effective the first day of the following plan year. Documentation of eligibility is required.

O. WAIVING HEALTH BENEFITS COVERAGE (VOLUNTARY)

A member may waive coverage by submitting a completed HSS application form and requesting that coverage be waived. It shall be the sole responsibility of the member to apply for a coverage waiver in accordance with these Rules. Unless otherwise noted in the subsections below, if an enrolled member waives coverage for himself, herself or any enrolled dependents, the termination date of coverage will vary depending on the member's premium contribution dates and corresponding coverage periods.

1. Voluntary Waiver of Health Benefits Coverage

- a.** A member may elect to waive coverage when he or she first qualifies for Health Service System eligibility per Section A.
- b.** A member may elect to waive coverage during open enrollment by submitting all required forms and documentation to the Health Service System no later than the required deadlines. Disenrollment from benefit plans takes effect the first day of the following plan year.

- c. Based on the rules governing qualifying events set forth in Section G, a member may waive coverage outside of open enrollment by submitting required forms and documentation by the deadlines prescribed by the Health Service System.
- d. A retiree member may waive medical coverage for himself or herself or a dependent at any time by completing the Retiree Enrollment form and submitting to HSS for processing. Retiree dental coverage can only be waived during open enrollment, unless there is a qualifying event. (Section G.)
- e. A member may elect to waive enrollment in a health benefit plan for himself or herself, and any enrolled dependents, for the duration of an unpaid leave if appropriate notice and documentation is given to the Health Service System in advance or immediately upon the commencement of the unpaid leave. (See Section R.)

2. Duration of Voluntary Waived Health Benefits Coverage

- a. Waiver of coverage will remain in effect until lifted by the member, which shall only take place during the open enrollment or if there is a qualifying event. To enroll in coverage a member must complete the required enrollment application and submit required documentation to the Health Service System by applicable due dates.
- b. A member who has waived coverage and who loses group coverage through job displacement of a spouse or domestic partner may apply for coverage through the Health Service System within thirty (30) days of the last date of group coverage under the same provisions as provided for dependents in Section N.1.h.
- c. A member may waive coverage if other medical or dental coverage has been obtained. An application form and required documentation must be submitted to HSS within 30 days of the date other coverage begins. The waiver will be effective the first day of the coverage period following receipt of application. Exceptions to this rule may be made at the discretion of the Operations Manager .

3. Potential Impact of Waiving Employee Health Benefits on Eligibility For Retiree Health Benefits

Under City Charter Section A8.428, an active employee must participate in a Health Service System health plan while an active employee to qualify for participation in the Health Service System as a "Retired Person" at the rate established for retired employees after service, disability or vesting retirement. Charter Sections A8.428(a)(1) and (a)(4) require that "Retired Person(s)" be a "former member(s) of the Health Service System."

P. MEMBER PREMIUM CONTRIBUTIONS, EMPLOYER PREMIUM SUBSIDIES, AND DELINQUENCIES**1. Employer Premium Subsidy for Active Employee Members**

An active employee is eligible for the full employer contribution for their employer-subsided premium rate.

2. Employer Premium Subsidy for Retiree Members

- a) A Retiree Member hired before January 10, 2009 is eligible for the full employer contribution for his or her employer-subsidized premium rate with the following exception:
 - (1) A Retiree Member who retires after January 6, 2012, and who left employment before June 30, 2001, is not eligible for the Proposition E 50% reduction toward his or her premium (Charter Section A8.428(b)(3)(iii)) or the employer contribution of 50% of healthcare premiums for the first dependent (Charter Section A8.428(c)).
- b) A Retiree Member hired on or after January 10, 2009, who retired with a disability retirement, is eligible for the full employer contribution for his or her employer-subsidized premium rate.
- c) A Retiree Member hired on or after January 10, 2009, with ten (10) or more years of credited service (as determined by HSS), and who retires within 180 days of separation from employment, is eligible for the pro-rated employer contribution for his or her employer-subsidized premium rate based on the member's years of credited service:
 - (1) With twenty (20) or more years of credited service, the Retiree Member is eligible for the full employer contribution for his or her employer-subsided premium rate.
 - (2) With at least fifteen (15) years but less than twenty (20) years of credited service, the Retiree Member is eligible for the 75% employer contribution for his or her employer-subsided premium rate.
 - (3) With at least ten (10) years but less than fifteen (15) years of credited service, the Retiree Member is eligible for the 50% employer contribution for his or her employer-subsided premium rate.
 - (4) With at least five (5) years but less than ten (10) years of credited service, the Retiree Member must pay the full premium rate and is not eligible for any employer-subsided premiums.

3. Employer Premium Subsidy for Eligible Surviving Dependents of an Active Employee Member

- a) If the deceased active employee member was hired before January 10, 2009, the member's enrolled surviving spouse or surviving domestic partner is eligible for the full employer contribution for his or her employer-subsidized premium rate.
- b) If the deceased active member was hired on or after January 10, 2009 and had at least ten (10) years of credited service (as determined by HSS), the member's enrolled surviving spouse or surviving domestic partner is eligible for a pro-rated employer contribution rate, with an employer-subsidized premium rate based on the deceased member's years of credited service.
 - (1) The surviving spouse or surviving domestic partner of a deceased active member with twenty (20) or more years of credited service (as determined by HSS) will receive the full employer contribution to his or her employer-subsidized premium rate.
 - (2) The surviving spouse or surviving domestic partner of a deceased active member with more than fifteen (15) but less than twenty (20) years of credited service (as determined by HSS) will receive 75% of the employer contribution to his or her employer-subsidized premium rates.
 - (3) The surviving spouse or surviving domestic partner of a deceased active member with more than ten (10) but less than fifteen (15) years of credited service (as determined by HSS) will receive 50% of the employer contribution to his or her employer-subsidized premium rate.
 - (4) A surviving spouse or surviving domestic partner of a deceased active member who died in the line of duty, where the surviving spouse or surviving domestic partner is entitled to a death allowance, will receive the full employer contribution to his or her employer-subsidized premium rate.
 - (5) Surviving dependent children are charged the full premium and are not eligible for the employer-subsidized premium.

4. Employer Premium Subsidy for Eligible Surviving Dependents of a Retiree Member Hired Before January 10, 2009

A surviving spouse or surviving domestic partner of a deceased Retiree Member (as defined in Section A.8) hired before January 10, 2009, is eligible for the full employer contribution to his or her employer-subsidized premium rate.

5. Employer Premium Subsidy for Eligible Surviving Dependents of a Retiree Member Hired On or After January 10, 2009

- a. The surviving spouse or surviving domestic partner of a deceased Retiree Member who retired with a disability retirement under his or her retirement system is eligible for full employer contribution to his or her employer-subsidized premium rate.
- b. An enrolled surviving spouse or surviving domestic partner of a deceased Retiree Member who was hired on or after January 10, 2009, with at least ten (10) years of credited service (as determined by HSS), and retired within 180 days of separation from employment, is eligible for the pro-rated employer contribution rate for his or her employer-subsidized premium rate, based on the member's years of credited service:
 - (1) The surviving spouse or surviving domestic partner of a deceased Retiree Member with twenty (20) or more years of credited service (as determined by HSS) will receive the full employer contribution to their employer-subsidized premium rate.
 - (2) The surviving spouse or surviving domestic partner of a deceased Retiree Member with more than fifteen (15) but less than twenty (20) years of credited service (as determined by HSS) will receive 75% of the employer contribution to his or her employer-subsidized premium rate.
 - (3) The surviving spouse or surviving domestic partner of a deceased Retiree Member with more than ten (10) but less than fifteen (15) years of credited service (as determined by HSS) will receive 50% of the employer contribution to his or her employer-subsidized premium rate.

6. Additional Rules for Employer Premium Subsidy for Eligible Surviving Dependents

- a. A surviving spouse or surviving domestic partner of a retiree member may elect a lump-sum settlement without affecting eligibility (Section B.5) or the employer contribution to the employer-subsidized premium rate.
- b. The surviving spouse or surviving domestic partner who remarries, or enters into a new domestic partnership, does not lose his or her current coverage including current employer-subsidized premium rate. However, no new dependents can be added. (See section B.5.)
- c. Eligible surviving dependent children, designated as the first dependent, will receive the 50% employer Charter contribution toward the healthcare premiums of the retired Health Service System member's first dependent. Other eligible surviving dependent children are charged the full premium, and are not eligible for the employer-subsidized premium rate.

7. Members and Surviving Dependents Not Subject to Payroll or Pension Deductions

- a.** It is the responsibility of the member, or surviving dependent, to make payments directly to the Health Service System for employee and retiree premium contributions which are not, or cannot be, made by payroll or pension deductions.
- b.** Members not subject to payroll, or retirement pension, deductions must pay the Health Service System directly by applicable due dates.
- c.** Premium contributions are due by the last day of the effective coverage period. See Appendix A.

8. Delinquent Payments

- a.** Any member premium contributions not paid when due shall constitute delinquent payments. After any payment becomes delinquent, the Health Service System shall provide to each affected member a notice of delinquency. Such notice shall be addressed to the current address on file with HSS, and shall be sent by U.S. mail. Such delinquency notice shall indicate that, unless all premium contributions are paid by the due date specified, coverage shall be terminated on the last day of the coverage period in which full payment was made.
- b.** If member fails to pay all delinquent premium contributions not made by the due date specified in the notice, coverage shall be terminated as of the last day of the coverage period in which full payment was made. HSS shall provide each affected member, or surviving dependent, a notice of termination of coverage. If payment is made within 14 calendar days of notice of termination, HSS will reinstate coverage with a \$50 reinstatement charge.
- c.** Members, and surviving dependents, will be allowed one period of delinquent payment per benefit year. Repeated payment delinquency periods will result in termination of coverage.
- d.** Partial payment of delinquent premium contributions shall not be sufficient to avoid or delay termination. Any such partial payment received by the Health Service System shall be applied to the most delinquent full coverage period. Premium contributions insufficient for a full coverage period will be returned or refunded.
- e.** An employee member who does not make required premium contributions while on authorized leave will have his or her health plan benefits terminated. The health plan benefits in which he or she was enrolled prior to going on leave will resume on the first day of the coverage period following his or her return to active employee status, provided the employee notifies the Health Service System in writing within thirty (30) days of the date he or she returns to work.

- f. Notwithstanding anything to the contrary contained herein, if any applicable memorandum of understanding should require that the Health Service System continue coverage for any insured whose employee premium contributions are delinquent hereunder, then the Health Service System shall not terminate such insured so long as the insured's employer has provided written notice to the Health Service System of the memorandum of understanding, and all employee premium contributions are paid to the Health Service System by such employer when due.

**Q. TERMINATION OF HEALTH BENEFITS COVERAGE
(INVOLUNTARY)**

1. Unless noted in the subsections below, termination date of coverage will vary depending on the member's premium contribution dates and corresponding coverage periods.
2. When a member is delinquent in the payment of employee or retiree premium contributions, benefits coverage for the member and any enrolled dependents will be terminated. (See Section P.8.)
3. If a member does not supply the Health Service System with all required eligibility documentation by required deadlines, including a Social Security number for himself or herself and/or any enrolled dependents, benefits coverage will be terminated. (See Section C: Eligibility Documentation Required.)
4. If a member does not maintain correct address and contact information on file with the Health Service System and cannot be contacted after a minimum of five attempts over two years to contact the member, benefits coverage will be terminated. **A member terminated for failure to keep current his or her address and contact information may seek reinstatement during the next open enrollment period.** (see Section C.4.)
5. Benefits of a member or dependent who becomes ineligible for any reason shall terminate on the last day of the coverage period for which full premium payments have been received. In the event that the date of ineligibility cannot be determined, termination shall be effective on the last day of the coverage period in which discovery of ineligibility occurs. (See Section E for member penalties that

will be incurred when a member fails to notify the Health Service System when a member's dependent becomes ineligible.)

6. Failure to comply with the conditions and requirements set forth in these Rules may result in retroactive termination of coverage.
7. Upon termination of a member's coverage, dependent coverage shall also be terminated.
8. An eligible member who has had benefits terminated may re-enroll himself or herself and his or her eligible dependents during annual open enrollment, with benefits coverage to commence the first day of the following plan year.

R. EMPLOYEES ON AUTHORIZED UNPAID LEAVE

Eligibility for membership in the Health Service System continues for the duration of all approved unpaid leaves. If an employee does not notify the Health Service System regarding his or her preference for either continuing or waiving coverage prior to going on authorized unpaid leave, existing health coverage will continue and the employee will be responsible for making all required health premium payments to the Health Service System by applicable due dates. Employees must notify HSS in advance or immediately upon their leave to either waive coverage or arrange for payment of employee premium contributions while on leave.

1. Continuing Coverage While on Authorized Unpaid Leave

While on authorized leave, an employee can continue existing coverage for himself or herself and enrolled dependents. Employees may not make changes to medical or dental coverage after unpaid leave has begun. If an employee chooses to continue coverage while on authorized unpaid leave, he or she must make all required health premium payments directly to the Health Service System by applicable due dates. To return premium contributions to active status, employees must immediately notify the Health Service System—no later than thirty (30) days of returning to work.

2. Waiving Coverage While on Authorized Unpaid Leave

At any time during an authorized leave, an employee may waive his or her existing coverage. To waive coverage, an employee must notify the Health Service System and submit all required forms and documentation prior to the start of leave. Employee must immediately notify the Health Service System—no later than thirty (30) days of returning to work in order to resume coverage and return premium contributions to active status. Coverage will resume the first day of the next coverage period following HSS notification of return to work.

3. Educational Leave and Personal Leave

Membership in the Health Service System continues for the duration of the approved leave. For the first twelve (12) weeks, the City subsidy continues and the member is only responsible for employee premium contribution amounts. If the

approved leave continues beyond twelve (12) weeks, and the City subsidy ends, the member is responsible for paying the entire premium amount, which is the combined total of the employee's and employer's premium contributions. Payments must be made directly to the Health Service System by the applicable due dates.

4. Leave for Employment as an Employee Organization Officer or Representative

Membership in the Health Service System continues for the duration of the approved leave. For the first twelve (12) weeks, the City subsidy continues and the member is only responsible for employee premium contribution amounts. If the approved leave continues beyond twelve (12) weeks, and the City subsidy is discontinued, the member is responsible for paying entire premium contribution amount directly to the Health Service System by the applicable due dates. In certain cases, the union in which the member is serving will pay the cost of the member's health and/or dental insurance. In these cases, it is still the member's responsibility to make sure the premiums are paid. The Health Service System will not seek payment directly from the member's union.

5. Family Care Leave

While a member is on family care leave, Health Service System coverage continues as long as the member continues to pay any premium portion that was deducted from his or her paycheck. The City subsidy continues for the duration of the family care leave. The member is responsible for ensuring that the required health coverage payments are paid directly to the Health Service System by the applicable due dates.

6. Personal Leave Following Family Care Leave

If a member has been on family care leave, has maintained his or her health coverage, and continues his/her leave by personal leave for the same reason, then the City subsidy continues for the duration of the leave. The member is responsible for ensuring that the required health coverage payments are paid directly to the Health Service System by the applicable due dates.

S. COBRA CONTINUATION OF HEALTH BENEFITS COVERAGE

1. Pursuant to the federally mandated Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), and any subsequent federal legislation regarding COBRA, members and dependents who have lost coverage for the following reasons shall be entitled to elect COBRA continuation coverage under the Health Service System.

a. COBRA Qualifying Events for Employees

- (1) The employee’s employment is terminated (voluntarily or involuntarily) for reasons other than gross misconduct.
- (2) The employee’s regular work hours are reduced, resulting in loss of coverage.

b. COBRA Qualifying Events for an Employee’s Spouse or Legal Domestic Partner Who is Covered on the Employee’s Health Benefit Plan

- (1) Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct
- (2) Reduction in the hours worked by the covered employee
- (3) Covered employee's becoming entitled to Medicare
- (4) Divorce or legal separation of the covered employee
- (5) Death of the covered employee

c. COBRA Qualifying Events for Dependent Children Covered on an Employee’s Health Benefit Plan

- (1) Loss of dependent child status under either Health Service System or health benefit plan vendor rules
- (2) Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct
- (3) Reduction in the hours worked by the covered employee
- (4) Covered employee's becoming entitled to Medicare
- (5) Divorce or legal separation of the covered employee
- (6) Death of the covered employee

2. Duration of COBRA Coverage

The duration of COBRA coverage listed below may be extended (or shortened) in accordance with provisions in the original federal Act as well as subsequent federal and state legislation relating to COBRA.

COBRA QUALIFYING EVENT	INDIVIDUALS ELIGIBLE	DURATION OF COBRA COVERAGE
<ul style="list-style-type: none"> • Employee’s termination • Employee’s reduction in working hours 	<ul style="list-style-type: none"> • Employee • Spouse • Dependent child 	<p>18 months from date active employee coverage ends</p>

COBRA QUALIFYING EVENT	INDIVIDUALS ELIGIBLE	DURATION OF COBRA COVERAGE
<ul style="list-style-type: none"> • Covered employee’s death • Covered employee’s divorce or legal separation 	<ul style="list-style-type: none"> • Spouse • Dependent child 	<p>36 months from date active employee coverage ends</p>
<ul style="list-style-type: none"> • Loss of dependent child status 	<ul style="list-style-type: none"> • Child 	<p>36 months from date active employee coverage ends</p>

3. A COBRA-eligible individual who elects COBRA coverage will have a contribution rate which shall not exceed 102 percent of the applicable contract rate.
4. The deadlines for notices and payments shall be the same with respect to dependents as the deadlines applicable to employee members with COBRA coverage.
5. Dependents may elect continuation coverage for themselves as individuals, or in combination with each other and/or the eligible member, consistent with COBRA.
6. Employees and dependents who have exhausted continuation coverage under federal COBRA, may be eligible for Cal-COBRA if they are entitled to less than 36 months of federal COBRA. (Continuation coverage under both federal and state coverage will not exceed 36 months.) Self-funded plans, including UHC (City Plan), are not eligible for Cal-COBRA.

T. OTHER PUBLIC AGENCIES ELIGIBLE TO PARTICIPATE IN THE HEALTH SERVICE SYSTEM

1. Election to Participate

San Francisco Administrative Code Section 16.700 authorizes specified public agencies other than the City & County of San Francisco to participate in the Health Service System, and to determine, by resolution of the appropriate governing body, the officers and employees who are eligible to enroll in the System. If a resolution electing to participate in the Health Service System is filed with the System on or before April 1st, then the participating agency and its employees, retirees, and dependents shall be eligible to enroll the following January 1st. These time requirements may be modified only with the approval of the Health Service Board.

2. Reports and Payments

A participating agency shall perform the functions necessary to enroll its employees and to submit timely and accurate reports and payments as may be

required by the Director of the Health Service System; provided, however, that the Director may not impose any reporting or payment requirements that differ from those applicable to the City & County of San Francisco, without approval of the Health Service Board.

3. Terminating Participation

A participating agency may end its participation in the Health Service System by filing a resolution of its governing body with the Health Service Board. The resolution must be filed with the Health Service Board no later than April 1st to be effective the following January 1st. Coverage of all agency employees, retirees and dependents will terminate on December 31st, the end of the plan year. The resolution electing to end participation in the Health Service System is irrevocable after it is filed with the Health Service Board. An agency may not file a resolution electing to resume participation in the Health Service System for five (5) years after the effective date of its exit from the Health Service System.

4. Exclusive Plans

A participating agency may not maintain for its employees any medical plan or program offering hospital and medical care, other than the plans offered by the Health Service System, except as expressly agreed to by the Health Service Board.

U. MEMBER APPEALS AND GRIEVANCES

1. Members who have a grievance with the HSS determination of credited service or their eligibility for retiree health benefits and employer-sponsored premium subsidies must submit their grievance and supporting documents in writing to:
San Francisco Health Service System
Attention: Member Appeals
1145 Market Street, Suite 300
San Francisco, CA 94103
2. Members who have a grievance with a specific benefit plan must first try and resolve their grievance through the plan's member assistance process. Grievances will not be considered by the Health Service System until this action is taken and documentation is submitted to HSS.
3. Members are advised that grievances relating to medical service received (or not received) from a Health Maintenance Organization (HMO) plan must be filed with the California Department of Managed Healthcare (DMHC). Grievances relating to Preferred Provider Organization (PPO) medical services must be filed with the

California Department of Insurance (DOI). Grievances related to a self-insured plan are filed with Health Service System.

4. Members having grievances that cannot be resolved to the satisfaction of the member may submit the facts in writing to:
San Francisco Health Service System
Attention: Member Appeals
1145 Market Street, Suite 300
San Francisco, CA 94103
5. Member grievances must be submitted within sixty (60) days of the event giving rise to the grievance or the denial of the grievance by the member's specific benefit plan under Section U.2. above.
6. The Health Service System shall consider each appeal or grievance and shall notify the member of its decision within sixty (60) days of receiving a member grievance
7. Any member dissatisfied with the Health Service System's decision shall retain the right to appeal the decision in writing to the Health Service Board. Such appeal must be made within fifteen (15) business days after the date the Health Service System mails its decision to the member at the member's last known address on file with the Health Service System. The Health Service Board may grant an extension of time upon the showing of good cause
8. City Charter Section 12.200(5) requires the Health Service Board receive, consider and, within sixty (60) days after receipt, act upon any matter pertaining to the policies of, or appeals from, the Health Service System submitted to it in writing by any member or any person who has contracted to render medical care to the members.
9. The appeal to the Health Service System Board shall specifically identify the basis of the member's disagreement with the Health Service System decision in writing.
10. Prior to the Health Service System Board hearing, the Health Service System shall serve a written response to the member's grievance upon the member and the Board.
11. The Health Service System Board shall grant, deny or otherwise respond to all written appeals submitted consistent with City Charter Section 12.200(5).
12. All actions taken by the Health Service Board shall be final.
13. All appeals to the Health Service System Board shall be heard in closed session, unless the member requests that it be held in open session. The Health Service Board minutes shall not reflect any member-identifiable information relating to appeals.
14. Members shall be allowed to bring a personal representative of their choosing to the Health Service Board hearing, along with any other witnesses the member

believes may have direct knowledge of the facts underlying the member's claim. The Health Service System shall also be allowed to bring any witnesses it believes will help the Board in its decision-making process. The Health Service System Board may exclude any witness upon a finding that their testimony would be duplicative, without foundation and/or not relevant to the member's claim.

V. RULES OF INTERPRETATION

The Health Service System has absolute discretionary authority to control and manage the operation and administration of the Health Service System, to correct errors, and to construe and interpret the Health Service System Rules including, but not limited to, determinations regarding benefits, eligibility and qualifying status change events. All decisions and interpretations of the Health Service System and the Health Service Board shall be conclusive and binding upon all persons, and shall be given the greatest deference permitted by law.

Any activity or transaction between members, dependents and the Health Service System not explicitly determined by these Rules remains under the discretion of the Health Service System and/or the Health Service Board. To the extent these Rules conflict with the City Charter, the express language of the Charter, and not these Rules, shall apply.

APPENDIX A: BENEFITS COVERAGE PERIODS

For January 1, 2019 through December 31, 2019, benefit coverage periods for members on a bi-weekly premium payment schedule of twenty-six (26) premium payments per year:

1	-	December 29, 2018	-	January 11, 2019
2	-	January 12, 2019	-	January 25, 2019
3	-	January 26, 2019	-	February 8, 2019
4	-	February 9, 2019	-	February 22, 2019
5	-	February 23, 2019	-	March 8, 2019
6	-	March 9, 2019	-	March 22, 2019
7	-	March 23, 2019	-	April 5, 2019
8	-	April 6, 2019	-	April 19, 2019
9	-	April 20, 2019	-	May 3, 2019
10	-	May 4, 2019	-	May 17, 2019
11	-	May 18, 2019	-	May 31, 2019
12	-	June 1, 2019	-	June 14, 2019
13	-	June 15, 2019	-	June 28, 2019
14	-	June 29, 2019	-	July 12, 2019
15	-	July 13, 2019	-	July 26, 2019
16	-	July 27, 2019	-	August 9, 2019
17	-	August 10, 2019	-	August 23, 2019
18	-	August 24, 2019	-	September 6, 2019
19	-	September 7, 2019	-	September 20, 2019
20	-	September 21, 2019	-	October 4, 2019
21	-	October 5, 2019	-	October 18, 2019
22	-	October 19, 2019	-	November 1, 2019
23	-	November 2, 2019	-	November 15, 2019
24	-	November 16, 2019	-	November 29, 2019
25	-	November 30, 2019	-	December 13, 2019
26	-	December 14, 2019	-	December 27, 2019

APPENDIX A: BENEFITS COVERAGE PERIODS *(continued)*

For January 1, 2019 – December 31, 2019, benefit coverage periods for members on a twice-monthly premium payment schedule of twenty-four (24) premium payments:

1	-	January 1, 2019	-	January 15, 2019
2	-	January 16, 2019	-	January 31, 2019
3	-	February 1, 2019	-	February 15, 2019
4	-	February 16, 2019	-	February 28, 2019
5	-	March 1, 2019	-	March 15, 2019
6	-	March 16, 2019	-	March 31, 2019
7	-	April 1, 2019	-	April 15, 2019
8	-	April 16, 2019	-	April 30, 2019
9	-	May 1, 2019	-	May 15, 2019
10	-	May 16, 2019	-	May 31, 2019
11	-	June 1, 2019	-	June 15, 2019
12	-	June 16, 2019	-	June 30, 2019
13	-	July 1, 2019	-	July 15, 2019
14	-	July 16, 2019	-	July 31, 2019
15	-	August 1, 2019	-	August 15, 2019
16	-	August 16, 2019	-	August 31, 2019
17	-	September 1, 2019	-	September 15, 2019
18	-	September 16, 2019	-	September 30, 2019
19	-	October 1, 2019	-	October 15, 2019
20	-	October 16, 2019	-	October 31, 2019
21	-	November 1, 2019	-	November 15, 2019
22	-	November 16, 2019	-	November 30, 2019
23	-	December 1, 2019	-	December 15, 2019
24	-	December 16, 2019	-	December 31, 2019

APPENDIX A: BENEFITS COVERAGE PERIODS *(continued)*

For January 1, 2019 – December 31, 2019, benefit coverage periods for members on a monthly premium payment schedule of twelve (12) premium payments:

1 - January 1, 2019	- January 31, 2019
2 - February 1, 2019	- February 28, 2019
3 - March 1, 2019	- March 31, 2019
4 - April 1, 2019	- April 30, 2019
5 - May 1, 2019	- May 31, 2019
6 - June 1, 2019	- June 30, 2019
7 - July 1, 2019	- July 31, 2019
8 - August 1, 2019	- August 31, 2019
9 - September 1, 2019	- September 30, 2019
10 - October 1, 2019	- October 31, 2019
11 - November 1, 2019	- November 30, 2019
12 - December 1, 2019	- December 31, 2019